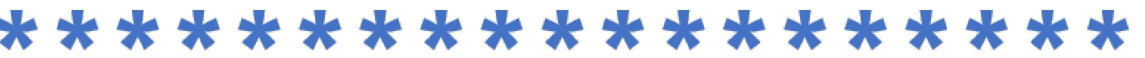

Welcome to Open Enrollment!

OPEN ENROLLMENT 2024

PLEASE FEEL FREE TO CALL US AT ANY TIME:

STEVE ZODIKOFF
(925) 932-0424
STEVE@ZODIKOFFINSURANCE.COM

2024 Health Insurance Increase
Medical Cost Comparison 50% vs. 33%

$500.00
$450.00
$400.00
$350.00
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00

EE E/S E/C E/Family EE E/S E/C E/Family EE E/S E/C E/Family EE E/S E/C E/Family

■ 50% CHC and 50% Employee BS EE Share/Chk ■ 67% CHC and 33% Employee

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2024 Employee Benefits Cost Per Check-Full-Time Employees

Employee Dependent Contributions Per Paycheck are:
EE: Employee Only; E/S=Employee and Spouse; E/C=Employee and Child(ren); E/Family=Employee and Family

Type	Current	50% CHC and 50% Employee	67% CHC and 33% Employee	Difference
		BS EE Share/Chk		
EE	$30.00	$68.38	$40.00	$28.38
E/S	$184.83	$261.35	$194.83	$66.52
E/C	$156.14	$225.35	$166.14	$59.21
E/Family	$334.68	$449.33	$344.68	$104.65
		KaiCA EE Share/Chk		
EE	$30.00	$73.65	$40.00	$33.65
E/S	$185.63	$275.98	$195.63	$80.35
E/C	$140.58	$216.96	$150.58	$66.38
E/Family	$292.62	$416.15	$302.62	$113.53
		KaiNW EE Share/Chk		
EE	$30.00	$52.04	$40.00	$12.04
E/S	$138.28	$182.37	$148.28	$34.09
E/C	$117.63	$157.31	$127.63	$29.68
E/Family	$241.56	$307.69	$251.56	$56.13
		KP Fdn EE Share/Chk		
EE	$30.00	$37.37	$40.00	-$2.63
E/S	$145.24	$161.00	$155.24	$5.76
E/C	$136.29	$151.37	$146.29	$5.08
E/Family	$246.52	$269.98	$256.52	$13.46
		PF Dent EE Share/Chk		
EE	$10.00	SAME	SAME	
E/S	$21.62	SAME	SAME	
E/C	$26.78	SAME	SAME	
E/Family	$38.40	SAME	SAME	
		VSP EE Share/Chk		
EE	$0.00	SAME	SAME	
E/S	$0.55	SAME	SAME	
E/C	$0.55	SAME	SAME	
E/Family	$1.10	SAME	SAME	

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Deductible	
Self-only Deductible per Year (for a Family of one Member)	None
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	None
Family Deductible per Year (for an entire Family)	None
Out-of-Pocket Maximum [1]	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$1,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$1,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$2,000

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KAISER NORTHWEST HMO

Office Visits	You pay
Routine preventive physical exam	$0
Telehealth (phone/video)	$0
Primary Care	$20
Specialty Care	$30
Urgent Care	$40

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KAISER NORTHWEST HMO

Hospital Services	You pay
Ambulance Services (per transport)	$75
Emergency services	$200 (Waived if admitted)
Inpatient Hospital Services	$100 per day up to $500 per admission
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$50

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KAISER NORTHWEST HMO

Medications (outpatient)	You pay
Prescription drugs (up to a 30 day supply)	$15 generic / $30 preferred brand / $50 non-preferred brand
Mail Order Prescription drugs (up to a 90 day supply)	$30 generic / $60 preferred brand / $100 non-preferred brand

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KAISER NORTHWEST HMO

Benefits	Inside Network
Plan deductible	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
	Individual out-of-pocket limit: $2,000 Family out-of-pocket limit: $4000

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KAISER FOUNDATION OF WA HMO

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KAISER FOUNDATION OF WA HMO

Outpatient services (Office visits)	$20 copay primary/$30 copay specialty
Hospital services	**Inpatient services:** $250 copay, per admit **Outpatient surgery:** $125 copay

Prescription drugs (some injectable drugs may be covered under Outpatient services)	Generic/Brand/Non-Preferred/Specialty $15/$30/$60/20% up to $250 per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply

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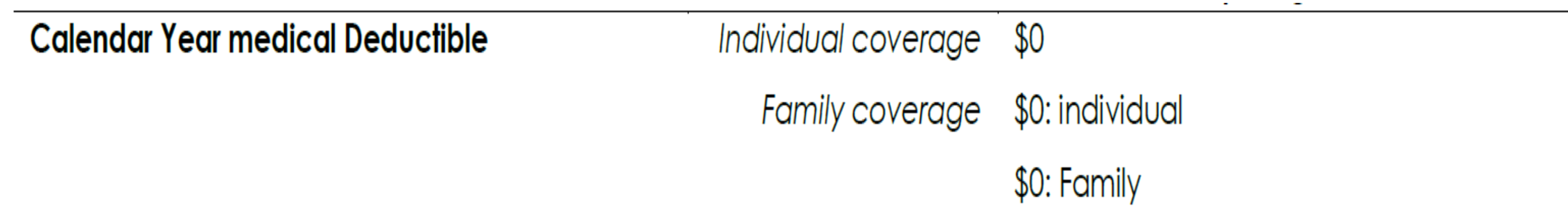
KAISER FOUNDATION OF WA HMO

Active Choice® Plus 300 20 80/60



Calendar Year medical Deductible		
	Individual coverage	$0
	Family coverage	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$3,000	$10,000
Family coverage	$3,000: individual $6,000: Family	$10,000: individual $20,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

How Your Active Choice Plan Works

Active Choice is a PPO plan with three categories of Benefits impacting the Deductible:

- Preventive Care Category – Available at no cost to you. These services are not subject to any Deductible.
- Category 1 – Certain routine care services. You can use your First Dollar Services credit towards these services before any Deductible applies.
- Category 2 – All other Covered Services. These services are subject to any Deductible.

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

Preventive Care Category	Your payment	
	When using a Participating Provider[3]	When using a Non-Participating Provider[4]
Preventive Health Services[6]		
Preventive Health Services	$0	Not covered
California Prenatal Screening Program	$0	$0
Family planning		
Counseling, consulting, and education	$0	Not covered

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

Category 1: First Dollar Services – Outpatient Professional and Diagnostic[7]

		When using a Participating[3] or Non-Participating[4] Provider
First Dollar Services credit	*Individual coverage*	$300
	Family coverage	$600

Blue Shield credits you with a dollar amount each year to use for certain routine care services. These routine care services are called First Dollar Services.

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

Category 1: First Dollar Services - Outpatient Professional and Diagnostic[7,8]

The First Dollar Services credit is available for Category 1 First Dollar Services listed in this table. After the First Dollar Services credit is exhausted, you are responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.	Your payment **When using a Participating Provider[3]**	**CYD[2] applies**	**When using a Non-Participating Provider[4]**
Specialist care office visit	$20/visit		40%
Physician home visit	$20/visit		40%
Other professional services			
Other practitioner office visit	$20/visit		40%
Includes nurse practitioners, Physicians assistants, and therapists.			
Acupuncture services	$20/visit		40%
Up to 20 visits per Member, per Calendar Year.			
Chiropractic services	$20/visit		40%
Up to 12 visits per Member, per Calendar Year.			

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

Laboratory services, except emergency and surgery *Includes diagnostic Papanicolaou (Pap) test.*			
• Laboratory center	$20/visit		40%
• Outpatient Department of a Hospital	$20/visit		40% Subject to a Benefit maximum of $350/day
X-ray and imaging services, except emergency and surgery *Includes diagnostic mammography.*			
• Outpatient radiology center	$20/visit		40%

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

Category 2: Outpatient and Inpatient Facility-Based Services[8]

Your payment

	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency Services				
Emergency room services	$100/visit plus 20%		$100/visit plus 20%	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room Physician services	20%		20%	

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

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Category 2: Outpatient and Inpatient Facility-Based Services[8]

Your payment

	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]
Inpatient facility services			
Hospital services and stay	$500/admission plus 20%		40% Subject to a Benefit maximum of $600/day

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

Calendar Year Pharmacy Deductible *Per Member* $250

Prescription Drug Benefits[4,5]

Your payment

	When using a Participating Pharmacy[2]	CYPD[1] applies	When using a Non-Participating Pharmacy[3]	CYPD[1] applies
Retail pharmacy prescription Drugs *Per prescription, up to a 30-day supply.*				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	$15/prescription		25% plus $15/prescription	
Tier 2 Drugs	$30/prescription	✔	25% plus $30/prescription	✔
Tier 3 Drugs	$45/prescription	✔	25% plus $45/prescription	✔
Tier 4 Drugs	30% up to $250/prescription	✔	30% up to $250/prescription plus 25% of purchase price	✔

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BLUE SHIELD OF CA ACTIVE CHOICE PPO

blue of california

Eligibility	
Job Class	CALIFORNIA MEMBERS

Benefits Payable						
Network	Dental Point of Service (POS)					
	Calendar Year Deductible			Coinsurance (Policy Pays)		
	EPO	PPO	Non - Network	EPO	PPO	Non - Network
Unit 1 – Preventive	$0	$0	$50	100%	100%	100%
Unit 2 – Basic	$25	$50	$50	90%	80%	80%
Unit 3 – Major	$25	$50	$50	60%	50%	50%
Combined Maximums	Maximums for preventive, basic, and major procedures are combined for EPO, PPO and Non-Network. Calendar year EPO maximums are $2,500 per person. Calendar year PPO maximums are $2,500 per person. Calendar year non-network maximums are $2,500 per person.					

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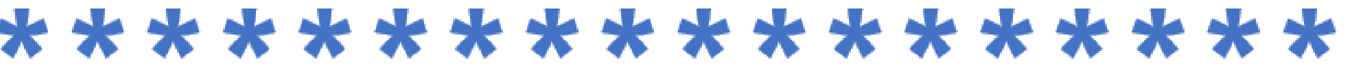
PRINCIPAL DENTAL PPO



PRIZE QUESTION

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Your Principal Dental PPO covers how many routine cleanings per year?

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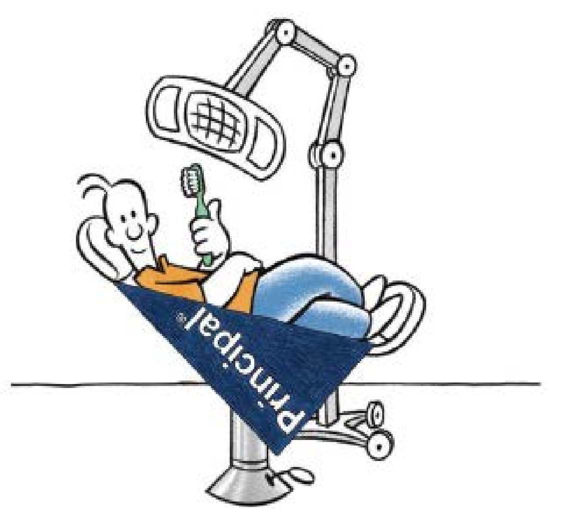
PRINCIPAL DENTAL PPO



Using the Maximum Accumulation Benefit

Your dental coverage includes the Maximum Accumulation Plan, which allows you to increase your maximum benefit each year when you regularly seek dental care. The maximum benefit is the most your dental design will pay for in one calendar year. Increasing your maximum benefit by rolling over unused dollars means you could pay less out of pocket each year.

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2024

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PRINCIPAL
DENTAL PPO

Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$20
Prescription Glasses		$20
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance • Every calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Progressive lenses • Average savings of 20-25% on other lens enhancements • Every calendar year	$0

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VISION SERVICE PLAN

Get an

Extra $40

to spend on

Choose one of these frame brands and $40 will automatically be applied to your purchase when you use your benefits.

Columbia • Longchamp
McAllister • Nike • Pure®

Available only to VSP® members with applicable plan benefits. Offers are only available through VSP network doctors and in-network locations.

Coupon not required to redeem offer. Void where prohibited. Offer valid through January 31, 2023.

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All other brands or marks are the property of their respective owners. 106337 VCCM Classification: Public

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VISION SERVICE PLAN

PRIZE QUESTION

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On your VSP coverage, when you purchase prescription glasses (with frames up to $130 allowance) you have a $20 copay. What is the additional cost to get Progressive Lenses?

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VISION SERVICE PLAN

GROUP TERM LIFE	
Benefit Amount	$50,000

Accidental Death & Dismemberment (AD&D) Coverage	
Benefit Amount	Your benefit is equal to your group term life benefit amount if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, your loss may be covered. You may be paid: • **Full benefit** when you lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • **Half of the benefit** when you lose: one hand / one foot / sight of one eye. • **One-fourth of the benefit** when you lose the thumb and index finger on the same hand. The loss must occur within 365 days of the accident.

CHC

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GROUP TERM LIFE/ AD&D

VOLUNTARY TERM LIFE

	Employee Life Benefits	Spouse Life Benefits	Child Life Benefits
Benefit Amount	You may choose to purchase benefits in increments of $10,000	You may choose to purchase benefits in $5,000 increments	For eligible children 14 days or older, you may choose to purchase benefits of • $2,500, or • $5,000, or • $7,500, or • $10,000 Eligible children under 14 days of age receive $1,000.
Minimum	$10,000	$5,000	Not Applicable
Maximum	$500,000	$150,000	Not Applicable
		Cannot exceed 100% of your benefit amount	
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are under age 70: $130,000	Proof of good health is required for life insurance amounts greater than: If your spouse is under age 70: $30,000	Not Applicable

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VOLUNTARY TERM LIFE/AD&D

VOLUNTARY LONG-TERM DISABILITY

Benefits Payable	
Primary Monthly Benefit	60% of your predisability earnings up to $6,000.
Benefit Amount	Primary monthly benefit less other income sources
Definition of Earnings	W2 - 1 year average
Benefit Qualification	
Elimination Period	90 days
Own Occupation Period	2 years
Maximum Benefit Payment Period	To age 65
Additional Benefits	
Rehabilitation Incentive Benefit	5% increase in the monthly benefit percentage
Survivor Benefit	Three times your primary monthly benefit to your survivor.
Limitations & Exclusions	
Pre-Existing Conditions	3 months prior/12 months insured

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VOLUNTARY
LONG-TERM DISABILITY

During the elimination period and the own occupation period, one of these situations must apply:	**Residual Disability** • You are not totally disabled and while working in your own occupation, as a result of sickness or injury, you are unable to earn 80% or more of your predisability earnings. **Total Disability** • You are unable to perform with reasonable continuity, the substantial and material duties necessary to pursue your own occupation and you are not working in your own occupation.

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VOLUNTARY
LONG-TERM DISABILITY

How do I get help?

Call us for help with life's ups and downs. We're here 24/7 to connect or refer you to a professional who can help with:

- Marriage, family and relationship issues.
- Problems in the workplace.
- Stress, anxiety and sadness.
- Grief, loss or responses to traumatic events.
- Concerns about your use of alcohol or drugs.

Your privacy

EAP services are confidential. Your privacy is important to us, and it is protected by state and federal laws.

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LIFEWORKS/TELUS HEALTH

EMPLOYEE ASSISTANCE PROGRAM

LIFE WORKS/TELUS HEALTH

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PRIZE QUESTION

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Under your Lifeworks/Telus Health EAP, how many in-person telephonic or web-based video consultations with a professional are available at no cost to you, per incident, per calendar year?

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LIFEWORKS/TELUS HEALTH

Eligible employees and their dependents can call Lifeworks/TELUS Health EAP for help 24/7. Customer Care Professionals will help you find the right resources and services including counselors, who can provide counseling sessions, coordinate the appropriate treatment, and provide referrals if needed. The Lifeworks app has many helpful tools and can be downloaded on Apple or Android phones from your device's app store. Help and tools can also be accessed thru their website at:

Website: **login.lifeworks.com**
Username: **calhydro**
Password: **eap**

For more information or to get assistance in making an appointment, call the Lifeworks/TELUS Health Employee Assistance Program at **1-800-433-7916.**

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LIFEWORKS/TELUS HEALTH

EMPLOYEE ASSISTANCE PROGRAM

LIFEWORKS/TELUS HEALTH

OPEN ENROLLMENT 2024

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FLEXIBLE SPENDING ACCOUNT (FSA)

HOW YOUR FSA WORKS

Your FSA is a spending account that can be used to pay for a variety of healthcare expenses.

TWO GREAT PERKS COME WITH YOUR FSA:

1. You will have access to your entire election on the first day of the plan year.
2. The funds are taken out of your paycheck "pre-tax" (meaning they are subtracted from your gross earnings before taxes) throughout the course of the year. That means you are increasing your take-home pay simply by participating!

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FLEXIBLE SPENDING ACCOUNT (FSA)

WHAT CAN I SPEND MY FSA FUNDS ON?

The IRS determines what expenses are eligible under an FSA. Below are some examples of common eligible expenses.

Copays, deductibles, and other payments you are responsible for under your health plan.

Routine exams, dental care, prescription drugs, eye care, and hearing aids.

Prescription glasses and sunglasses.

Certain over-the-counter (OTC) healthcare expenses such as Band-aids, medicine, First Aid supplies, etc. **Note:** OTC medicines require a doctor's prescription to be eligible.

Diabetic equipment and supplies, durable medical equipment, and qualified medical products or services provided by a doctor.

Dependent Care FSA

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FLEXIBLE SPENDING ACCOUNT (FSA)

HOW IT WORKS

A Dependent Care FSA is an account that can be used to pay for the care of an eligible child, adult, or elder dependent (as defined by the IRS). Dependent Care FSAs help you save money by allowing you to set aside pre-tax dollars to pay for eligible dependent care expenses.

WHAT IS COVERED

You can use the funds in your Dependent Care FSA to pay for:

- Day care
- Before-school or after-school care
- In-home babysitting—that enables you to be gainfully employed—by someone who is not your dependent (for tax purposes)
- Care for a dependent adult/elder, enabling you to be gainfully employed
- Nanny services, nursery school, or preschool
- Summer day camps

Next Steps…

- Check your e-mail for personalized Ease Login.
- Log in, review your 2024 options, and elect! If you do not make new elections, all current elections will continue….*except FSA!*
- Complete enrollment no later than Friday 12/15/2023.

PLEASE FEEL FREE TO CALL US AT ANY TIME:

STEVE ZODIKOFF

(925) 932-0424

STEVE@ZODIKOFFINSURANCE.COM

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THANK YOU!