Northern Solano County Association Realtors

OPEN ENROLLMENT MADE EASY

OPEN ENROLLMENT PERIOD	**November 7 to November 28**
EFFECTIVE DATE OF CHANGES	**December 1, 2016**
RESPONSE DEADLINE	**Monday, November 28**

WHY IS THIS OPEN ENROLLMENT IMPORTANT TO YOU?

N.S.C.A.R will continue to offer Kaiser and Western Health Advantage medical plans. As well as Delta Dental and MES Vision.

IMPORTANT – IF YOU ARE CURRENTLY ENROLLED:

Effective December 1, 2016 your current plan automatically rolls over to the same plan you have now.

Your recent bill from American River Benefit Administrators reflects the new premium effective December 1, 2016.

IT IS IMPORTANT THAT YOU REVIEW THE ATTACHED INFORMATION AND YOUR BILL AS YOU HAVE AN OPPORTUNITY TO CHOOSE A DIFFERENT MEDICAL PLAN BUT WE NEED TO HAVE YOUR DECISION NO LATER THAN MONDAY, NOVEMBER 28.

- **NOW is your opportunity to enroll if you are eligible and not currently enrolled.**
- **NOW is your opportunity to enroll your eligible dependents if not currently enrolled.**
  Eligible Dependents include your spouse or domestic partner and children or children of your domestic partner (natural, step, adopted, foster or a child placed in your legal custody) who are up to age 19 or up to age 26 if not covered under another employer's group health plan.

FOR RATE INFORMATION EMAIL PRJ INSURANCE MARKETING INC. questions@prjinsurance.com

- If you decide not to take advantage of this Open Enrollment Period, your next opportunity will be in **November 2017** for an effective date of **December 1, 2017**, unless you experience a qualifying event.
- **A Qualifying Event is defined as:** Loss of other health insurance coverage such as through your spouse's group employer plan or MediCal; Loss of health insurance through an individual plan (only if loss of coverage is beyond your control such as a divorce or death, not to include an increase in cost); Adoptions; Birth of a child or Marriage. If you fall into any of these categories during the year, you have a 30-day window (from the event) to make changes or you will have to wait until the next Open Enrollment period.

As the insurance broker for N.S.C.A.R. we are happy to provide you with the attached medical Open Enrollment information. We are available to assist you in understanding the new ACA plans and guide you towards choosing the right medical plan for the next year. To make a change, please contact our office.

PRJ INSURANCE MARKETING, INC.
Kenneth Stamey, Broker CA 0679857
800-427-7074

KAISER PERMANENTE

December 1, 2016 - November 30, 2017

BENEFIT	Platinum 90 0/20 HMO
Lifetime Maximum	Unlimited
Calendar Year Deductible : Individual / Family	None
Calendar Year Max Out-of-Pocket: Individual / Family	$4,000 / $8,000 (Embedded)
Office Visit	$20 (Primary) $40 (Specialty)
Most Laboratory Tests	$20 Copay
Most X-rays & Diagnostics	$40 Copay
MRI/CT/PET	$150 Copay
Preventive Care Exam	$0 Copay
Hospitalization	$290 per Day (Days 1-5) per Admission
Outpatient Surgery	$290 Copay per Procedure
Emergency Room	$150 Copay (waived if admitted directly to hospital)
Urgent Care Center	$20 Copay
Maternity:	
Inpatient	$290 per Day (Days 1-5) per Admission
Prenatal/First Postpartum Visit	$0 Copay
Mental Health:	
Inpatient	$290 per Day (Days 1-5) per Admission
Outpatient	$20 Copay
Substance Abuse: Inpatient Detox Only	$290 per Day (Days 1-5) per Admission
Prescriptions:	(Up to a 30-Day Supply)
Generic	$5 Copay
Deductible (Brand Name)	None
Brand	$15 Copay
Pediatric Dental & Vision (Up to age 19)	
Deductible / Waiting Period	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild
Office Visit	$0 Copay
Cleaning & Exam	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure
Orthodontics (Medically Necessary)	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay
Adult Optical (Eyewear)	$175 allowance
Provider Restrictions	Kaiser

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

Over

KAISER PERMANENTE

December 1, 2016 - November 30, 2017

BENEFIT	Gold 80 0/35 HMO	Gold 80 500/30 HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible : Individual / Family	None	$500 / $1,000 (1)
Calendar Year Max Out-of-Pocket: Individual / Family	$6,200 / $12,400	$6,250 / $12,500
Office Visit	$35 (Primary) $55 (Specialty)	$30 Copay
Most Laboratory Tests	$35 Copay	$20 Copay
Most X-rays & Diagnostics	$50 Copay	$20 Copay
MRI/CT/PET	$250 Copay	$250 Copay
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Outpatient Surgery	$655 Copay per Procedure	$600 Copay per Procedure After Deductible
Emergency Room	$250 Copay (waived if admitted directly to hospital)	$250 Copay After Deductible (waived if admitted directly to hospital)
Urgent Care Center	$35 Copay	$30 Copay
Maternity:		
Inpatient	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Prenatal/First Postpartum Visit	$0 Copay	$0 Copay
Mental Health:		
Inpatient	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Outpatient	$35 copay	$30 copay
Substance Abuse: Inpatient Detox Only	$655 per Day (Days 1-5) per Admission	$600 per Day (Days 1-5) per Admission After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$15 Copay	$15 Copay
Deductible (Brand Name)	None	None
Brand	$50 Copay	$50 Copay
Pediatric Dental & Vision (Up to age 19)		
Deductible / Waiting Period	$0 Deductible & No Waiting Periods	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild	$350 per Child / $700 Multichild
Office Visit	$0 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure	$85 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure	$65 - $350 Copay Depending on Procedure
Orthodontics (Medically Necessary)	$350 Copay	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frames & lenses or contact lenses per calendar year	One standard pair of frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered
Provider Restrictions	Kaiser	

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

(1) This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copayments or coinsurance after meeting his or her individual deductible, or whenthe family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of pocket maximum is met.

KAISER PERMANENTE

December 1, 2016 - November 30, 2017

BENEFITS	Silver 70 1000/50 HMO	Silver 70 1500/45 HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible: Individual/family	$1,000 / $2,000 (1)	$1,500 / $3,000 (1)
Calendar Year Max Out-of-Pocket: Individual/family	$6,500 / $13,000 (1)	$6,500 / $13,000 (1)
Office Visit	$50 Copay	$45 Primary / $70 Specialty Copay
Most Laboratory Tests	$40 Copay	$35 Copay
Most X-rays & Diagnostics	$40 Copay	$65 Copay
MRI/CT/PET	30% After Deductible	$250 Copay
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	30% After Deductible	20% After Deductible
Outpatient Surgery	30% After Deductible	20 % (Deductible Waived)
Emergency Room	30% After Deductible	$300 Copay After Deductible (waived if admitted directily to hospital)
Urgent Care Center	$50 Copay	$45 Copay
Maternity:		
Inpatient	30% After Deductible	20% After Deductible
Prenatal/Prenatal Care	$0 Copay	$0 Copay
Mental Health:		
Inpatient	30% After Deductible	20% After Deductible
Outpatient	$50 Copay	$45 Copay
Substance Abuse: Inpatient Detox Only	30% After Deductible	20% After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$25 Copay	$15 Copay
Deductible (Brand Name)	None	$250 Brand Name Deductible
Brand	$50 Copay	$55 Copay (After $250 drug deductible)
Pediatric Dental & Vision (Up to age 19)		
Deductible / Waiting Period	$0 Deductible & No Waiting Periods	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild	$350 per Child / $700 Multichild
Office visits	$20 Copay	$0 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure	$85 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure	$65 - $350 Copay Depending on Procedure
Orthodontics (medically necessary)	$350 Copay	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frames & lenses or contact lenses per calendar year	One standard pair of frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered
Provider Restrictions	Kaiser	

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

(1) This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copayments or coinsurance after meeting his or her individual deductible, or whenthe family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of pocket maximum is met.

KAISER PERMANENTE

December 1, 2016 - November 30, 2017

MAPPED FROM		Silver 70 HSA 1500/20 OR Bronze 60 HSA 3500/30
BENEFITS	Bronze 60 6000/70 HMO	Bronze 60 HSA 4500/40% HMO
Lifetime Maximum	Unlimited	Unlimited
Calendar Year Deductible: Individual/family	$6,000 / $12,000 (1)	$4,500 / $9,000 (1)
Calendar Year Max Out-of-Pocket: Individual/family	$6,500 / $13,000 (1)	$6,500 / $13,000 (1)
Office Visit	$70 Primary - After Deductible $90 Specialist - After dedictible	40% After Deductible
Most Laboratory Tests	$40	40% After Deductible
Most X-rays & Diagnostics	100% (up to out-of-pocket maximum)	40% After Deductible
MRI/CT/PET	100% (up to out-of-pocket maximum)	40% After Deductible
Preventive Care Exam	$0 Copay	$0 Copay
Hospitalization	100% (up to out-of-pocket maximum)	40% After Deductible
Outpatient Surgery	100% (up to out-of-pocket maximum)	40% After Deductible
Emergency Room	100% (up to out-of-pocket maximum)	40% After Deductible
Urgent Care Center	$70 After Deductible	40% After Deductible
Maternity:		
Inpatient	100% (up to out-of-pocket maximum)	40% After Deductible
Prenatal/Prenatal Care	$0	$0
Mental Health:		
Inpatient	100% (up to out-of-pocket maximum)	40% After Deductible
Outpatient	$70 After Deductible	40% After Deductible
Substance Abuse: Inpatient Detox Only	100% (up to out-of-pocket maximum)	40% After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 100-Day Supply)
Generic	100% per prescription up to $500 maximum After $500 drug deductible	40% After Plan Deductible
Deductible	$500	Subject to Plan Deductible (1)
Brand	100% per prescription up to $500 maximum After $500 drug deductible	40% After Plan Deductible
Pediatric Dental & Vision (Up to age 19)		
Deductible / Waiting Period	$0 Deductible & No Waiting Periods	$0 Deductible & No Waiting Periods
Annual Out-of-Pocket Maximum	$350 per Child / $700 Multichild	$350 per Child / $700 Multichild
Office visits	$0 Copay	$20 Copay
Cleaning & Exam	$0 Copay	$0 Copay
Periodontics	$85 - $350 Copay Depending on Procedure	$85 - $350 Copay Depending on Procedure
Restorative	$25 - $350 Copay Depending on Procedure	$25 - $350 Copay Depending on Procedure
Endodontics	$85 - $300 Copay Depending on Procedure	$85 - $300 Copay Depending on Procedure
Prosthodontics	$65 - $350 Copay Depending on Procedure	$65 - $350 Copay Depending on Procedure
Orthodontics (medically necessary)	$350 Copay	$350 Copay
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One standard pair of frames & lenses or contact lenses per calendar year	One standard pair of frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered
Provider Restrictions	Kaiser	

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th

(1) This plan has an embedded deductible and out-of-pocket maximum. Each family member will begin paying copayments or coinsurance after meeting his or her individual deductible, or whenthe family deductible is satisfied. Individual family members are no longer subject to cost sharing when they reach their individual out-of-pocket maximum, or when the family out-of pocket maximum is met.

WESTERN HEALTH ADVANTAGE

December 1, 2016 - November 30, 2017

Mapped From			Gateway 1800 HSA Gold HMO
BENEFITS	Gateway 30 Platinum HMO	Gateway 70 Platinum HMO	Gateway 2000 HSA Gold HMO
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Calendar Year Deductible:	None	None	$2,000 Single Coverage $2,600 Single w/ Family $4,000 Family Coverage
Calendar Year Max Out-of-Pocket:	$4,000 / $8,000	$4,000 / $8,000	$2,000 Single Coverage $2,600 Single w/ Family $4,000 Family Coverage
Office Visit	$30 per Visit	$20 per Visit	Covered in Full After Deductible
Preventive Services	Covered in Full	Covered in Full	Covered In Full
Diagnostic X-Ray & Lab	Covered in Full	Covered in Full	Covered in Full After Deductible
Imaging (CT/PET Scans & MRIs)	$100 per Visit	$100 per Visit	Covered in Full After Deductible
Hospitalization	$300 per Day, Days 1-3	30%	Covered in Full After Deductible
Outpatient Surgery Facility	$100 per Visit	$100 per Visit	Covered in Full After Deductible
Outpatient Surgery Professional	Covered in Full	Covered in Full	Covered in Full After Deductible
Emergency Room	$150 per Visit	$150 per Visit	Covered in Full After Deductible
Urgent Care Center	$50 per Visit	$50 per Visit	Covered in Full After Deductible
Maternity:			
Inpatient	$300 per Day, Days 1-3	30%	Covered in Full After Deductible
Prenatal/First Postpartum Visit	Covered in Full	Covered in Full	Covered in Full
Mental Health:			
Inpatient	$300 per Day, Days 1-3	30%	Covered in Full After Deductible
Outpatient	$30 per Visit	$20 per Visit	Covered in Full After Deductible
Substance Abuse:			
Inpatient Detox Only	$300 per Day, Days 1-3	30%	Covered in Full After Deductible
Prescriptions:	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)	(Up to a 30-Day Supply)
Generic	$10 Copay	$10 Copay	Covered in Full After Deductible
Deductible (Brand Name)	None	None	Medical Deductible Applies
Brand	$30 copay	$30 copay	Covered in Full After Deductible
Non Formulary	$50 copay	$50 copay	Covered in Full After Deductible
Pediatric Dental & Vision (Up to age 19)			
Annual Out-of-Pocket Maximum	None	None	None
Deductible / Waiting Period	$0 Deductible / No Waiting Period	$0 Deductible / No Waiting Period	$0 Deductible / No Waiting Period
Annual Maximum	N/A	N/A	N/A
Office Visit	$0 Copay	$0 Copay	$0 Copay
Diagnostic & Preventive:			
X-Ray, Exam, Cleanings	$0 Copay	$0 Copay	$0 Copay
Basic Services: Basic restorative	$40 - $365 Copay Depending on Procedure	$40 - $365 Copay Depending on Procedure	$40 - $365 Copay Depending on Procedure
Major Services: Crown, Cast, Prothodontists, Endodontics, Periodontics, Oral Surgery	$40 - $365 Copay Depending on Procedure	$40 - $365 Copay Depending on Procedure	$40 - $365 Copay Depending on Procedure
Orthodontics (Medically Necessary)	$1,000 Maximum	$1,000 Maximum	$1,000 Maximum
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One pair of standard frames & lenses or contact lenses per calendar year	One pair of standard frames & lenses or contact lenses per calendar year	One pair of standard frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered	Not Covered
Provider Restrictions	Western Health Advantage HMO		

Eligibility Guidelines - GUARANTEED ISSUE

WHA Members & Dependents	Members may apply at anytime except if you are a new member, then it is the 1st of the month following new membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th.

WESTERN HEALTH ADVANTAGE

December 1, 2016 - November 30, 2017

Mapped From			Gateway 5500B HSA Bronze HMO
BENEFITS	Gateway 1500 HSA Silver HMO	Gateway 4010 Gold HMO	Gateway 6000 HSA Bronze HMO
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Calendar Year Deductible:	$1,500 Single Coverage $2,600 Single w/ Family $3,000 Family Coverage	$1,000 Single Coverage $1,000 Single w/Family $2,000 Family Coverage	$6,000 Single Coverage $6,000 Single w/Family $12,000 Family Coverage
Calendar Year Max Out-of-Pocket:	$6,350 Single Coverage $6,350 Single w/ Family $12,700 Family Coverage	$6,350 Single Coverage $6,350 Single w/Family $12,700 Family Coverage	$6,000 Single Coverage $6,000 Single w/Family $12,000 Family Coverage
Office Visit Preventive Services	$20 per Visit After Deductible Covered in Full	$40 per Visit Covered in Full	Covered in Full After Deductible Covered In Full
Diagnostic X-Ray & Lab Imaging (CT/PET Scans & MRIs)	Covered in Full After Deductible 30% After Deductible	Covered in Full $250 per Visit	Covered in Full After Deductible Covered in Full After Deductible
Hospitalization Outpatient Surgery Facility Outpatient Surgery Professional	30% After Deductible 30% After Deductible Covered in Full	$500 per Day, Days 1-5 After Deductible $500 per Visit After Deductible Covered in Full	Covered in Full After Deductible Covered in Full After Deductible Covered in Full After Deductible
Emergency Room Urgent Care Center	30% After Deductible $50 per Visit After Deductible	$275 per Visit After Deductible $50 per Visit	Covered in Full After Deductible Covered in Full After Deductible
Maternity: Inpatient Prenatal/First Postpartum Visit	 30% After Deductible Covered in Full	 $500 per Day, Days 1-5 After Deductible Covered in Full	 Covered in Full After Deductible Covered in Full
Mental Health: Inpatient Outpatient	 30% After Deductible $20 per Visit After Deductible	 $500 per Day, Days 1-5 After Deductible $40 per Visit	 Covered in Full After Deductible Covered in Full After Deductible
Substance Abuse: Inpatient Detox Only	 30% After Deductible	 $500 per Day, Days 1-5 After Deductible	 Covered in Full After Deductible
Prescriptions: Generic Deductible (Brand Name) Brand Non Formulary	(Up to a 30-Day Supply) $25 After Deductible Medical Deductible Applies $50 After Deductible $75 After Deductible	(Up to a 30-Day Supply) $10 copay $250/$250 / $500 $30 Copay $50 Copay	(Up to a 30-Day Supply) Covered in Full After Deductible Medical Deductible Applies Covered in Full After Deductible Covered in Full After Deductible
Pediatric Dental & Vision (Up to age 19)			
Annual Out-of-Pocket Maximum	None	None	None
Deductible / Waiting Period	$0 Deductible / No Waiting Period	$0 Deductible / No Waiting Period	$0 Deductible / No Waiting Period
Annual Maximum	N/A	N/A	N/A
Office Visit	$20 Copay	$0 Copay	$0 Copay
Diagnostic & Preventive: X-Ray, Exam, Cleanings	 $0 Copay	 $0 Copay	 $0 Copay
Basic Services: Basic restorative	$55 - $365 Copay Depending on Procedure	$40 - $365 Copay Depending on Procedure	$40 - $365 Copay Depending on Procedure
Major Services: Crown, Cast, Prothodontists, Endodontics, Periodontics, Oral Surgery	 $55 - $365 Copay Depending on Procedure	 $40 - $365 Copay Depending on Procedure	 $40 - $365 Copay Depending on Procedure
Orthodontics (Medically Necessary)	$1,000 Maximum	$1,000 Maximum	$1,000 Maximum
Pediatric Vision (Up to age 19) Includes Exam and Eyewear	One pair of standard frames & lenses or contact lenses per calendar year	One pair of standard frames & lenses or contact lenses per calendar year	One pair of standard frames & lenses or contact lenses per calendar year
Adult Vision Exam	$0 Copay	$0 Copay	$0 Copay
Adult Optical (Eyewear)	Not Covered	Not Covered	Not Covered
Provider Restrictions	Western Health Advantage HMO		

Eligibility Guidelines - GUARANTEED ISSUE

WHA Members & Dependents	Members may apply at anytime except if you are a new member, then it is the 1st of the month following new membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1st - November 30th.

Delta Dental Plan Options through the Associations

Effective Date: December 01, 2016 - November 30, 2017

Insurance Carrier	DeltaCare USA	Delta Dental
Plan Name	Plan 11B	Fee For Service
Plan Type	HMO	DPO
Provider Network	DeltaCare USA Network ONLY	PPO or Premier Network
Calendar Year Maximum	Unlimited	$1,000
Deductible:	None	Single $50/Family $ 150
Waived for Preventive	Not Applicable	Yes
Diagnostic		*"Delta Pays" (A)*
Office Visit	$20 copay	$26.00
Periodic Oral Evaluation	No Charge	$17.00
Comprehensive Oral Evaluation	No Charge	$22.00
Bitewing X-rays	No Charge	$12.00 - $26.00
Other X-rays	No Charge	$5.00 - $50.00
Preventive		*"Delta Pays" (A)*
Cleanings Adult	No Charge	$40.00
	Additional Cleanings: $45.00	Not Applicable
Child through Age 13	No Charge	$32.00
	Additional Cleanings: $35.00	Not Applicable
		"Delta Pays" (A)
Restorative	No Charge - $240 copay	$53.00 - $148.00
Oral Surgery	No Charge - $110 copay	$26.00 - $175.00
Endodontics (Root Canals)	No Charge - $250 copay	$50.00 - $402.00
Periodontics (Deep Cleaning)	$80 copay - $280 copay	$39.00 - $448.00
		"Delta Pays" (A)
Waiting Period	None	None
Crowns	$55 copay - $240 copay	$343.00 - $391.00
Prosthodontics, Removable	$20 copay - $210 copay	$255.00 - $676.00
Prosthodontics, Fixed	$40 copay - $240 copay	$191.00 - $605.00
Orthodontia		
Pretreatment/Post Treatment	$200 copay / $70 copay	NOT COVERED
Limited Treatment Child to 19	$950 copay	
Limited Treatment 19 to Adult	$1,150 copay	
Comprehensive Treatment Child to 19	$1,700 copay	
Comprehensive Treatment 19 to Adult	$1,900 copay	
Monthly Premium Rate		
Subscriber Only	$38.80	$55.84
Subscriber+1	$58.47	$98.45
Subscriber+2 or more	$82.42	$129.24

(A) For each procedure, you are responsible for the portion of the dentist's fee that is more than the amount listed in the "Delta Dental Pays" column.

Vision Plan through Associations

Effective Date December 01, 2016 - November 30, 2017

MEDICAL EYE SERVICES (MES)		
Vision Benefits	**In-Network**	**Out-of-Network**
Deductible: **Exams** **Material**	 **$10 deductible** **$15 deductible**	 **$10 deductible** **$15 deductible**
Exam	**One comprehensive exam in any 24 consecutive months, with a follow-up exam at a 12 month interval.**	
Comprehensive Exam **Follow-Up Exam**	**No Charge** **No Charge**	**Up to $40** **Up to $20**
Lenses (per pair)	**1 pair of standard lenses in any 24 consecutive months, or at a 12 month interval if the prescription changes.**	
Frames	**1 standard frame in any 24 consecutive months.**	
	Up to retail cost of $100	**Up to $40**
Contact Lenses	**1 pair of standard lenses in any 24 consecutive months, or at a 12 month interval if the prescription changes.**	
Cosmetic/Convenience **Medically Necessary**	**Up to $105** **No Charge**	**Up to $100** **Up to $250**

Application Requirements

Member/Employer group applications may be submitted at any time. Applications for new hires should be enrolled within 30 days following the date of eligibility. Dependents must be enrolled during initial enrollment period. If a member enrolls at any other time than December, the annual rate will be pro-rated.

Premium Rates			
	Subscriber	**Subscriber & Spouse** **OR** **Subscriber & (1) Child**	**Subscriber** **&** **Family**
Monthly Rates	**$7.95**	**$14.95**	**$20.10**
Annual Rates	**$95.40**	**$179.40**	**$241.20**

Monthly rates available for groups with medical coverage upon request.

Other Services:

Long Term Care Plans
Long Term Disability Plans
Life Insurance Options
Medicare Supplements
Prescription Drug Plans

NEED HELP FINDING A PROVIDER?

WESTERN HEALTH ADVANTAGE

https://www.westernhealth.com/search-for-providers/?sp=home

ANTHEM BLUE CROSS

https://www.anthem.com/health-insurance/provider-directory/searchcriteria?qs=*dmobYvnDkpRF9B5i7bq78aM6zsOJDillMrp75xf57aA=&brand=abcbs

DELTA DENTAL

https://www.deltadentalins.com/find-a-

PREMIER ACCESS

https://mydental.guardianlife.com/secure/PAWEBSITE.PROVIDER.UI/WBSPrvNewSearch.as

MEDICAL EYE SERVICES

https://www.mesvision.com/homepage.htm