emplicity®
Employee Management Made Simple.

Employee Benefits Program

Emplicity PEO Benefit Plan Summaries.
Effective January 1, 2022.

Medical - Anthem Blue Cross PPO and HDHP Plans

Plans are available nationwide, a minimum of 5 enrollments required.

Plan Features	Elements PPO 5900 MV	Lumenos PPO HSA 4500	Solutions PPO 2500	Classic PPO 1000
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximums unless otherwise stated)	**In-Network:** $5,900/person; $11,800/family **Out-of-Network:** $11,800/person; $23,600/family	**In-Network:** $4,500/person; $9,000/family **Out-of-Network:** $6,000/person; $12,000/family	**In-Network:** $2,500/person; $5,000/family **Out-of-Network:** $5,000/person; $10,000/family	**In-Network:** $1,000/person; $2,000/family **Out-of-Network:** $5,000/person; $10,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless specifically stated*)	**In-Network:** $6,350/person; $12,700/family **Out-of-Network:** $12,700/person; $25,400/family	**In-Network:** $6,000/person; $12,000/family **Out-of-Network:** $12,000/person; $24,000/family	**In-Network:** $6,000/person; $12,000/family **Out-of-Network:** $12,000/person; $24,000/family	**In-Network:** $5,000/person; $10,000/family **Out-of-Network:** $10,000/person; $20,000/family
Physician and Hospital Services				
Physician's Office Visits Includes mental health, well-woman, well-baby, well-man, annual pap-smear, routine mammogram, and prostate exam, vision & hearing testing	**In-Network:** $35 visit 1st 3 visits deduct waived, Must meet deductible then 0% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** $25 copay, deductible waived **Out-of-Network:** 50% coinsurance	**In-Network:** $20 copay, deductible waived $40 copay, deductible waived **Out-of-Network:** 50% coinsurance
Hospital Inpatient Room and Board, Surgery, Anesthesia, Drugs/Supplies	**In-Network:** Must meet deductible, then 0% coinsurance **Out-of-Network:** Must meet deductible, then 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance $1000/day max
Outpatient Surgery	**In-Network:** Must meet deductible, then 0% coinsurance **Out-of-Network:** Must meet deductible, then 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance $350/visit max benefit
Emergency Room (*Copay waved if admitted)	**In-Network:** Must meet deductible, then 0% coinsurance **Out-of-Network:** Covered as In-Network	**In-Network:** 30% coinsurance **Out-of-Network:** Covered as In-Network	**In-Network:** $150 copay, then 30% coinsurance after deductible **Out-of-Network:** Covered as In-Network	**In-Network:** $150 copay, then 20% coinsurance after deductible **Out-of-Network:** Covered as In-Network
Urgent Care	**In-Network:** Must meet deductible, then 0% coinsurance **Out-of-Network:** Must meet deductible, then 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** $25 copay, deductible waived **Out-of-Network:** 50% coinsurance	**In-Network:** $20 copay, deductible waived **Out-of-Network:** 50% coinsurance
Prenatal Care and Inpatient (Hospital Inpatient Applies)	**In-Network:** $35 office visit for 1st 3, deductible waived, then 0% coinsurance **Out-of-Network:** Must meet deductible, then 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** $25 copay, deductible waived, 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** $20 copay office visits, deductible waived, 20% coinsurance **Out-of-Network:** 50% coinsurance
MRI/Imaging, Diagnostic Labs & X-Ray	**In-Network:** Must meet deductible, then 0% coinsurance **Out-of-Network:** Must meet deductible, then 50% co-insurance MRI/Imaging $800 maximum	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** 30% coinsurance **Out-of-Network:** 50% coinsurance	**In-Network:** 20% coinsurance **Out-of-Network:** 50% coinsurance
Prescription Drugs				
Retail Pharmacy In-Network (30 day supply if not specified) Dollar amounts listed are generic/formulary brand/non-formulary brand	$15 / $30 / $50 copay	$5/$20/$40 copay after deductible	$5-$20/$50/$70 copay	$5-$20/$40/$60 copay
Specialty Pharmacy In-Network (Includes many specialty drugs)	30% coinsurance up to $150	$60 copay retail $120 copay home delivery	30% coinsurance up to $250	30% coinsurance up to $250
Out-of-Network	50% coinsurance up to $250	50% coinsurance up to $250	50% coinsurance up to $250	50% coinsurance up to $250
Female Contraceptives	No charge - deductible waived	No charge - deductible waived	No charge - deductible waived	No charge - deductible waived

Plan summaries are for comparison, for full details refer to the Summary of Benefits Coverage (SBC).

Medical - Anthem Blue Cross HMO Plans

Plans are available in California

Plan Features	DED HMO 5900 MV	Value Ded HMO 2500	Value HMO 30	Classic HMO 30
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximums unless otherwise stated)	$5,900 per individual	$2,500 per individual	None	None
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless specifically stated*)	$6,350/person; $12,700/family	$6,500/person; $13,000/family	$6,500/person; $13,000/family	$3,500/person; $7,000/family
Lifetime Benefits Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Physician and Hospital Services				
Physician's Office Visits Includes mental health, routine health maintenance, preventative care: well-woman, well-baby, well-man, annual pap-smear, routine mammogram, and prostate exam, vision & hearing testing	$35 copay $70 copay/specialist Deductible waived	$30 copay $45 copay/specialist Deductible waived	$30 copay $40 copay/specialist	$30 copay $40 copay/specialist
Hospital Inpatient Room and Board, Surgery, Anesthesia, Drugs/Supplies	30% coinsurance	30% coinsurance	$500 copay, then 30% coinsurance	$500 copay
Outpatient Surgery	30% coinsurance	30% coinsurance	30% coinsurance	$250 copay
Emergency Room (*Copay waved if admitted)	$250 copay, then 30% coinsurance after deductible	$150 copay then 30% coinsurance	$250 copay	$250 copay
Urgent Care	$35 copay, deductible waived	$30 copay, deductible waived	$30 copay	$30 copay
Prenatal Care and Inpatient (Hospital Inpatient Applies)	$35 office visit, deductible waived, 30% coinsurance	$30 office visit, deductible waived, 30% coinsurance	$30 office visit, $500 admission then 30% coinsurance	$30 office visit, $500 admission
Diagnostic Lab & X-Ray	No charge	No charge	No charge	No charge
MRI/Imaging	$250 deductible waived	30% coinsurance	30% coinsurance	$100 copay
Prescription Drugs				
Tier 1 No deductible - Typically Generic Covers up to a 30 day supply (retail) or 90 day supply (home delivery).	$15 copay retail $15 copay home delivery	$5-$20 copay retail $12.50-$50 copay home delivery	$5-$20 copay retail $12.50-$50 copay home delivery	$5-$20 copay retail $12.50-$50 copay home delivery
Tier 2 Deductible - Typically Preferred	$500 deductible per person up to 3 max $50 copay retail $100 copay home delivery	$250 deductible per person up to 3 max $40 copay retail $120 copay home delivery	$250 deductible per person up to 3 max $40 copay retail $120 copay home delivery	$150 deductible per person up to 3 max $40 copay retail $120 copay home delivery
Tier 3 Deductible - Typically Non- Preferred	$500 deductible per person up to 3 max 30% coinsurance up to $150 retail, up to $300 home delivery	$250 deductible per person up to 3 max $75 copay retail $225 copay home delivery	$250 deductible per person up to 3 max $75 copay retail $225 copay home delivery	$150 deductible per person up to 3 max $60 copay retail $180 copay home delivery
Tier 4 Deductible - Typically Specialty	$500 deductible per person up to 3 max 30% coinsurance up to $150 retail, up to $300 home delivery	$250 deductible per person up to 3 max 30% coinsurance up to $250 retail and home delivery	$250 deductible per person up to 3 max 30% coinsurance up to $250 retail and home delivery	$150 deductible per person up to 3 max 30% coinsurance up to $250 retail and home delivery
Female Contraceptives	No charge - deductible waived	No charge - deductible waived	No charge - deductible waived	No charge - deductible waived

Plan summaries are for comparison, for full details refer to the Summary of Benefits Coverage (SBC).

Medical - Kaiser Permanente HMO Plans

Plans are available in California, a minimum of 3 eligible enrollments required.

Plan Features	Traditional HMO 15	Traditional HMO 25	DED DHMO 1500	HSA 2000	DED HMO 4500 MV
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximums unless otherwise stated)	None	None	$1,500/person; $3,000/family	$2,000/person; $2,800 any one member; $4,000/family	$4,500/person; $9,000/family
Calendar-Year Out-of-Pocket Expense Maximum (Excludes deductible unless specifically stated*)	$1,500/person; $3,000/family	$1,500/person; $3,000/family	$4,000/person; $8,000/family	$3,000/person; $3,000 any one member; $6,000/family	$6,000/person; $12,000/family
Physician and Hospital Services					
Physician's Office Visits Includes mental health, routine health maintenance, preventative care: well-woman, well-baby, well-man, annual pap-smear, routine mammogram, and prostate exam, vision & hearing testing	$15 copay	$25 copay	$20 copay, deductible waived	$30 copay after deductible	40% coinsurance after deductible
Hospital Inpatient Room and Board, Surgery, Anesthesia, Drugs/ Supplies, Includes Mental Health	$250 per admission	$500 per admission	20% Coinsurance	$250 copay after deductible	40% coinsurance after deductible
Outpatient Surgery	$15 copay	$25 copay	20% Coinsurance	$150 copay after deductible	40% coinsurance after deductible
Emergency Room (*Copay waved if admitted)	$50 copay	$100 copay	20% Coinsurance	$100 copay after deductible	40% coinsurance after deductible
Urgent Care	$15 copay	$25 copay	$20 copay, deductible waived	$30 copay after deductible	40% coinsurance
Prenatal Care and Inpatient	No charge office visits In-patient $250 per admission	No charge office visits In-patient $500 per admission	No charge office visits In-patient 20% coinsurance	No charge office visits, deductible waived In-patient $250 after deductible	No charge office visits, deductible waved In-patient 40% coinsurance
Diagnostic Lab & X-Ray	No charge	No charge	$10 copay; deductible waved	$10 copay after deductible	40% coinsurance after deductible
MRI/Imaging	No charge	No charge	20% coinsurance up to $50, deductible waived	$50 copay after deductible	40% coinsurance after deductible
Chiropractic (Subject to visit limits)	Not covered	Not covered	Not covered	Not covered	Not covered
Prescription Drugs					
Retail Pharmacy (30 day supply if not specified)	$10 Generic $20 Preferred, non-preferred	$15 Generic $30 Preferred & Non-preferred	$10 Generic $30 Preferred, non-preferred deductible waived	$10 Generic $30 Preferred, non-preferred deductible waived	Generic 30% coinsurance up to $50 deductible waived Preferred & non-preferred 40% coinsurance up to $100 after $250 drug deductible
Mail-Order Pharmacy (100 day supply if not specified)	$10 Generic $20 Preferred & non-preferred	$30 Generic $60 Preferred & Non--preferred	$20 Generic $60 Preferred, non-preferred deductible waived	$20 Generic $60 Preferred, non-preferred deductible waived	Generic 30% coinsurance up to $50 deductible waived Preferred & non-preferred 40% coinsurance up to $100 after $250 drug deductible
Specialty Pharmacy (Includes many specialty drugs.)	30% Coinsurance up to $150	30% coinsurance up to $150	30% Coinsurance up to $150, deductible waived	30% coinsurance up to $150	40% up to $200 after $250 drug deductible
Female Contraceptives	No charge	No charge	No charge - deductible waived	No charge - deductible waived	No charge - deductible waived

Plan summaries are for comparison, for full details refer to the Summary of Benefits Coverage (SBC).

Dental Plans

The minimum employer contribution is 50%, and 50% of eligible employees must participate for all plans (PPO and DHMO) combined.

MetLife Dental Plan Features	DMO (California)	PPO Low (EPO Nationwide)	PPO High (Nationwide)
Calendar-Year Deductible (Deductible applies where specifically stated; doesn't apply to out-of-pocket expense maximums unless otherwise stated)	None	$50/person $150/family	$25/person $75/family
Annual Maximum Benefit (per member)	None	$1,000/person	$2,000/person
Office Visit	$5 copay	$0 Copay	$0 Copay
Diagnostic and Preventative			
Cleaning, X-rays, Fluoride Treatments, Sealants	No charge	$0 copay	$0 copay
Basic			
Fillings **Extractions** **Oral Surgery** **Endodontics** - Root Canal Therapy **Periodontics** - Scaling and Planning	0 - $40* Minimum copay per service 0 - $75* Minimum copay per service $0 - $75* Minimum copay per service $0 - $125* Minimum copay per service $20 - $175* Minimum copay per service	**In-Network:** 20% **Out-of-Network:** 50%	**In-Network:** 20% **Out-of-Network:** 30%
Major			
Bridges **Full and Partial Dentures** **Prosthodontics** - Porcelain Crown	$100 - $250 minimum copay per bridge* $110 - $125 minimum copay* $100 - $215 minimum copay per crown*	**In-Network:** 50% **Out-of-Network:** 75%	**In-Network:** 50% **Out-of-Network:** 50%
Orthodontics Lifetime Maximum	Up to 24 months treatment with $1,450 copay - Children & Adults	$1,000 - Child up to age 19	$1,500 - Adults & Children up to age 19

Beam Dental Plan Features	Beam Low (plan pays based on PPO fee)	Beam High (In-network PPO fee; out of network 95th Percentile UCR)
Individual Annual Deductible	$50 in/out-of-network	$25 in/out-of-network
Family Annual Deductible	$150 in/out-of-network	$75 in/out-of-network
Annual Maximum Benefit (per Member)	$1,250	$2,500
Preventative		
Routine Cleaning, Dental X-Rays	100% in/out-of-network	100% in/out-of-network
Minor Restorations		
Extractions, Endodontics (Root Canal), Periodontics (Scaling & Planing)	80% in-network; 50% out-of-network	80% in/out-of-network
Major Restorations		
Prosthodontics (Crown), Bridge, Implants	50% in-network, 25% out-of-network	50% in/out-of-network
Orthodontic Lifetime Maximum	50%; $1,000 lifetime limit; children to age 19 only	50%; $1,500 lifetime limit; children to age 19 only

1One cleaning every 6 months, DMO 2 Additional cleanings available at additional charge
**Copays and coinsurance vary depending on work preformed. Always ask for pre-treatment estimate before beginning any procedures*

Plan summaries are for comparison, for full details refer to the Summary of Benefits Coverage (SBC).

Vision - VSP Plans

Plans available nationwide, the minimum employer contribution is 50% and 50% of eligible employees participating.

Plan Features	Choice Plan	Signature Plan
Well Vision	Exam $10 copay, one per year	Exam $10 copay, one per year
Single Lenses	Covered in full Every other calendar year	Covered in full Every calendar year
Lined Bifocal Lenses	Covered in full Every other calendar year	Covered in full Every calendar year
Lined Trifocal Lenses	Covered in full Every other calendar year	Covered in full Every calendar year
Lenticular Lenses	Covered in full Every other calendar year	Covered in full Every calendar year
Frames	Up to $130 (see allowances) Every other calendar year	Up to $140 (see allowances) Every calendar year
Contact Lens Exam	Up to $60 copay Every other calendar year	Up to $60 copay Every calendar year
Contact Lenses	Up to $130 (see allowances) Every other calendar year	Up to $140 allowance Every calendar year
Standard Progressive Lenses	$0	$0
Premium Progressive Lenses	$80 - $90 copay	$0
Custom Progressive Lenses	$120 - $160 copay	$0

Additional savings and discounts available for additional pairs of glasses, laser vision correction, and retinal screening. Benefits are reduced for out-of-network providers. Contact member services for out-of-network plan details.

Plan summaries are for comparison, for full details refer to the Summary of Benefits Coverage (SBC).

Life Insurance

Anthem Blue Cross Life and Health Insurance Company

Employer Paid Basic Life Insurance	
Basic Life Insurance Rate (Monthly, per $1,000 of coverage)	$0.11
AD&D Insurance Rate (Monthly, per $1,000 of coverage)	$0.02
Face Value	$15,000 / $25,000 / $50,000 / $100,000 1x salary up to $250,000

Anthem Voluntary Life Insurance *			
Attained Age	**Employee**	**Spouse**	**Child $10K**
<25	$0.95	$0.48	$1.00
25 - 29	$0.87	$0.44	
30 - 34	$0.90	$0.45	
35 - 39	$1.08	$0.54	
40 - 44	$1.50	$0.75	
45 - 49	$2.25	$1.13	
50 - 54	$3.43	$1.72	
55 - 59	$5.42	$2.71	
60 - 64	$8.09	$4.05	
65 - 69	$12.25	$6.13	
70 - 74	$26.55	$13.28	
75 - 79	$56.25	$28.13	
80 - 84	$155.25	$77.63	

* Voluntary Life Insurance - Employee & Spouse Premium rates are based on the employee's age. Employee insurance rates are per $10,000 increment; Maximum Coverage: the lesser of 5x salary or $300,000. Spouse insurance rates are per $5,000 increment. Maximum Coverage: 50% of employee's coverage. Dependent Child(ren) up to age 26 coverage at a rate of $1.00 for $10,000 coverage. Premium applies to all children.

Conditions	
Increments	Employee: $10,000 up to the lesser amount of $300,000 or 5X annual earnings Spouse: $5,000 up to $150,000, not to exceed 50% of employee amount Child: $10,000, not to exceed 50% of employee amount
Guarantee Issue Amount	Employee: $150,000 (Newly eligible) Spouse: $25,000 (Newly eligible) Child: $10,000 (Newly eligible)

Disability Insurance

Anthem Life Insurance Company

	Short-Term Disability (Voluntary)		Long-Term Disability (Employer-Paid)	
	California	Nationwide - Except California	Base Plan	Enhanced (Buy-up)
Elimination Period	7 days	7 days	180 days	180 days
Maximum Benefit %	30% of weekly earnings	60% of weekly earnings	50% of monthly earnings	60% of monthly earnings
Maximum Benefit	Up to $1,500 weekly	Up to $1,500 weekly	Up to $2,500 monthly	Up to $6,000 monthly
Benefit Duration	26 weeks	26 weeks	2 years, up to age 70	Up to 5 years or SSNRA
Pre-existing Limitations	3 / 12	3 / 12	3 / 12	3 / 12
Participation Requirement	15% of eligible employees	15% of eligible employees	100% of eligible employees	100% of eligible employees
Monthly Premium STD per $10 of weekly benefit LTD per $100 of covered payroll	See rate table	See rate table	$0.101 per $100 of covered payroll	$0.151 per $100 of covered payroll
Own Occupation Definition	N/A	N/A	24 months	24 months

Anthem Voluntary Short-Term Disability Rates **		
Attained Age	**California**	**Non-California**
<25	$0.29	$0.46
25 - 29	$0.30	$0.44
30 - 34	$0.31	$0.48
35 - 39	$0.30	$0.49
40 - 44	$0.32	$0.57
45 - 49	$0.35	$0.66
50 - 54	$0.42	$0.83
55 - 59	$0.52	$1.08
60 - 64	$0.61	$1.30
65 - 69	$0.69	$1.47
70 - 74	$0.89	$1.91
Over 74	$1.16	$2.48

** Voluntary STD - Rates are per $10 of benefit; $1,500 per week maximum benefit. At Open Enrollment Benefit is calculated off of Age and Salary effective January 1. California benefit 30% of weekly salary, Outside of California benefit 60% of weekly salary.

	Employee Assistance Program (High)	Resource Advisor (Low)
Face-to-face or Online Counseling	Up to 6 per issue	Up to 3 per issue
Legal Consultation	30 minute meeting, discounted fees, free library	Phone consultation, discounted fees
Financial Consultation	Phone consultation	Phone consultation
ID Recovery	Risk level checks, assistance with reporting theft	ID monitoring, credit report reviews, theft assistance
Online Resources	Videos, articles, e-learning, webinars	Tools, referrals, more
Daily Living Resources	Work-life consultation	Tools, referrals, more
Crisis Consultation	Toll-free emergency number	
Monthly Premium	$1.33 per eligible employee per month	Included at no charge

Plan summaries are for comparison, for full details refer to the Summary of Benefits Coverage (SBC).

Voluntary Supplemental Insurance

Aflac Short-Term Disability (Voluntary)		
	California Residents	Residing Outside of California
Benefit Period	Choose your plan: Payments begin the 7th day of disability for a maximum of 3 months or 14th day of disability for a maximum of 6 months.	
Benefit Amount	40% of weekly earnings	60% of weekly earnings
Maximum Benefit	Up to a maximum monthly benefit of $3,000	Up to a maximum monthly benefit of $3,000
Pre-existing Conditions	An illness or injury for which you received treatment or where symptoms were present within 12 months prior to your effective date of coverage. A disability that begins in the first 12 months after your effective date will not be covered if it results from a pre-existing condition.	
Pregnancy	Covered after 9 months of coverage; Maximum six weeks for non-cesarean delivery and eight weeks for cesarean delivery	

Aflac Voluntary Short-Term Disability Rates **		
Attained Age	7 / 7 / 3 Month	14 / 14 / 6 Month
18 - 49	$0.4529	$0.3699
50 - 64	$0.4738	$0.4072
65 - 74	$0.5400	$0.5054

** Voluntary STD - Rates are per $10 of benefit
Benefits are not reduced when other income is received

Additional Voluntary Plans - Offered to all Benefit Eligible Employees
Offered to all Benefit Eligible Employees
Aflac Accident
Aflac Critical Illness
Aflac Hospital Indemnity
NortonLifeLock Identity Theft Protection
MetLaw Legal Plan

Plan summaries are for comparison, for full details refer to the Summary of Benefits Coverage (SBC).

Contact us with any questions.

Email: Benefits@emplicity.com

Phone: (877) 476-2339, Option 5

Hours: Mon. - Fri. 8am to 5pm PST

emplicity®