



***"Great Benefits for Great Employees
Platinum Benefits for Platinum Employees"***



Choice of Employee Benefits Plans

MEDICAL

- Four HMO Plan Designs
- Point of Service Plan (POS)

DENTAL

- HMO Plan
- PPO Plan

VISION

- HMO Plan

LIFE, AD&D and LONG TERM DISABILITY (LTD)

- Group Life & AD&D Plan – employer paid
- Group LTD –employer paid
- Voluntary Life Plan – employee paid

FLEXIBLE SPENDING ACCOUNTS (FSA)

- Dependent Care Account
- Un-reimbursed Medical Account

Subject to change and position – contact KimStaff and Platinum management for complete details

MEDICAL PLAN FEATURES

The goal of *Kimstaff* is to provide you with affordable, quality health care benefits. Our Medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. *Kimstaff* offers a choice of Medical Plans through Kaiser Permanente and PacifiCare.



		KAISER SCHEDULE OF BENEFITS	
		STANDARD HMO OPTION	HIGH HMO OPTION
PRIMARY CARE OFFICE VISITS		\$20 Copay	\$10 Copay
PRESCRIPTION DRUG Employee Pays		\$15 Copay up to 100 day supply	\$15 Copay up to 100 day supply
EMERGENCY ROOM		\$50 Copay (waived if admitted)	\$50 Copay
DEDUCTIBLE Individual		None	None
Family		None	None
MAXIMUM OUT-OF-POCKET Individual		\$1,500	\$1,500
Family		\$3,000	\$3,000
PLAN LIFETIME MAXIMUM		Unlimited	Unlimited
ROUTINE PHYSICAL EXAMS		\$20 Copay	\$10 Copay
WELL BABY CARE Office Visit (well baby visit)		\$5 Copay up to 24 months	100% up to 24 months
HOSPITAL CHARGES Inpatient		\$250 Copay per admission, then 100%	100%
Outpatient		100% after \$20 Copay	100%
OUTPATIENT LAB & X-RAY		100%	100%
SUBSTANCE ABUSE PROGRAM Inpatient		No Charge (detox only)	No Charge (detox only)
Outpatient		\$20 Copay (per individual visit) \$10 Copay (group therapy)	\$10 Copay (per individual visit) \$5 Copay (group therapy)
MENTAL HEALTH Inpatient (per calendar year)		\$250 Copay per admission, up to 30 days	100% up to 30 days
Outpatient (per calendar year)		\$20 Copay for individual visits	\$10 Copay for 20 individual visits
MONTHLY COSTS Employee Only		\$152.44	\$167.57
Employee Plus One Dependent		\$304.88	\$335.14
Employee & Family		\$431.41	\$474.22

ALL MEDICAL BENEFITS ARE AB88 COMPLIANT

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MEDICAL PLAN FEATURES



	PACIFICARE SCHEDULE OF BENEFITS	
	STANDARD HMO	HIGH HMO
OFFICE VISITS	\$15 Copay	\$20 Copay
SPECIALIST OFFICE VISITS Referral Required	\$30 Copay	
PRESCRIPTION DRUG Employee Pays	\$20 Generic \$30 Brand Managed Formulary	\$20 Generic \$30 Brand Managed Formulary
PRESCRIPTION DRUG MAIL ORDER 90 day supply	\$40 Generic \$60 Brand	\$40 Generic \$60 Brand
EMERGENCY ROOM	\$100 Copay	\$50 Copay (waived if admitted as inpatient)
DEDUCTIBLE Individual	None	None
Family	None	None
MAXIMUM OUT-OF-POCKET Individual	\$4,000	\$1,500
Family	3x maximum per family	3 individual maximum per family
PLAN LIFETIME MAXIMUM	Unlimited	Unlimited
ROUTINE PHYSICAL EXAMS	\$15 Copay	\$20 Copay
WELL BABY CARE Office Visit (well baby visit)	\$15 Copay applies if infant ill at time of visit, otherwise 100%	\$20 Copay applies if infant ill at time of visit, otherwise 100%
HOSPITAL CHARGES Inpatient	\$250 per day	\$250 Copay
OUTPATIENT LAB & X-RAY	100%	100%
SUBSTANCE ABUSE PROGRAM Inpatient	\$250 Per Day Detox Only	\$250 Copay
Outpatient	\$30 Copay Detox Only	100% Detox Only
MENTAL HEALTH Inpatient (per calendar year)	Not Covered	Not Covered
Outpatient (per calendar year)	\$30 Copay per visit 20 limit (Crisis Intervention only)	\$35 Copay per visit 20 limit (Crisis Intervention only)
MONTHLY COSTS Employee Only	\$163.77	\$180.76
Employee Plus One Dependent	\$330.41	\$364.99
Employee & Family	\$483.83	\$534.66

ALL MEDICAL PLANS ARE AB88 COMPLIANT

MEDICAL PLAN FEATURES



	PACIFICARE SCHEDULE OF BENEFITS		
	POS In-Network	POS Preferred Providers	POS Non Preferred Providers
OFFICE VISITS	\$10 Copay	\$20 Copay	40% Copay
PRESCRIPTION DRUG Employee Pays	\$10 Generic \$25 Brand Managed Formulary	\$10 Generic \$25 Brand Managed Formulary	\$10 Generic \$25 Brand Managed Formulary
PRESCRIPTION DRUG MAIL ORDER 90 Day Supply	\$20 Generic \$50 Brand	\$20 Generic \$50 Brand	\$20 Generic \$50 Brand
EMERGENCY ROOM	\$35 Copay (waived if admitted)	Covered In-Network	
DEDUCTIBLE Individual	None	\$500 deductible is combined for Preferred and Non Preferred providers Max 3 Individual deductibles per family	
Family	None		
MAXIMUM OUT-OF-POCKET Individual	\$800	\$3,000	\$6,000
Family	\$2,400	\$9,000	\$18,000
PLAN LIFETIME MAXIMUM	Unlimited	\$2,000,000	
ROUTINE PHYSICAL EXAMS	\$10 Copay	\$20 Copay under age 18; not covered over age 18	40% Copay under age 18; not covered over age 18
HOSPITAL CHARGES Inpatient	100%	20% Copay	40% Copay
Outpatient	100%	20% Copay	40% Copay
OUTPATIENT LAB & X-RAY	100%	\$20 Copay	40% Copay
SUBSTANCE ABUSE PROGRAM Inpatient	100% Detox Only	40% Copay detox only	40% Copay detox only
Outpatient	100% Detox Only	\$20 Copay detox only	40% Copay detox only
MENTAL HEALTH Inpatient (per calendar year)	Not Covered	Not Covered	Not Covered
Outpatient (per calendar year)	\$35 Copay Per visit - limit 20	30% Copay Max. \$50 per visit up to 20 visits per year (crisis intervention only)	40% Copay Max. \$50 per visit up to 20 visits per year (crisis intervention only)
MONTHLY COSTS Employee Only Employee Plus One Dependent Employee & Family		\$ 347.14 \$ 706.51 \$1032.97	

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DENTAL PLAN FEATURES

Next to medical insurance, dental coverage is the single most requested benefit among employees and an important part of your health care package. Regular dental care is important to your overall health and well-being. The **Kimstaff** Dental Plan is provided by Delta Dental. Coverage is available for you and your dependents.



	DELTA SCHEDULE OF BENEFITS	
	DELTA CARE DMO (PMI) PLAN 750	DELTA PREFERRED NATIONAL PPO
DEDUCTIBLE Individual	None	\$50
Family	None	\$150
PLAN YEAR MAXIMUM	Unlimited	\$1,000
DIAGNOSTIC/PREVENTIVE Visit/Exam/Cleaning/X-Rays	No Cost	100% PPO/80% Non-PPO
RESTORATIVE (FILLINGS) Cavities in Primary/Permanent	No Cost	80% PPO/80% Non-PPO
PERIODONTICS Gingivectomy (per quadrant)	\$125 Copay	50% PPO/50% Non-PPO
ENDODONTICS Pulpotomy/Root Canal (single)	No Cost	50% PPO/50% Non-PPO
CROWNS & BRIDGES Crown/ Bridges/ Unit	\$90 porcelain fused to high noble metal	50% PPO/50% Non-PPO
PROSTHETICS Dentures Full/ Partial	\$110 Copay to \$125 Copay	50% PPO/50% Non-PPO
ORTHODONTIA	Start up fees (excluding records) \$350 Dependent Children to age 19 \$1,600 Adults & Students \$1,800	50% up to \$1,000 Lifetime Benefit
MONTHLY COSTS		
Employee Only	\$ 17.38	\$ 45.42
Employee Plus One Dependent	\$ 28.66	\$ 74.94
Employee & Family	\$ 42.37	\$120.21

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VISION PLAN FEATURES



DELTA VISION SCHEDULE OF BENEFITS				
VOLUNTARY VISION HMO - PROGRAM				
PLAN BENEFITS	PLAN BENEFITS			
OFFICE VISIT	No Cost*			
VISION EXAM Every 12 months	No Cost*			
LENSES (Glass or Plastic)** Single vision Single vision lenticular	No Cost** Lab cost + \$5 Copay			
BIFOCAL Flat top 25 bifocal Lenticular Executive bifocal	No Cost** Lab cost + \$5 Copay \$5 Copay			
TRIFOCAL Executive trifocal Double D trifocal	Lab cost + \$5 Copay Lab cost + \$5 Copay			
LENTICULAR	Lab cost + \$5 Copay			
CONTACT LENSES (In lieu of glasses)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Hard lenses \$75</td> <td style="text-align: center;">Soft lenses \$125</td> <td style="text-align: center;">Extended wear \$175</td> </tr> </table>	Hard lenses \$75	Soft lenses \$125	Extended wear \$175
Hard lenses \$75	Soft lenses \$125	Extended wear \$175		
Visually Necessary Professional fees & materials	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Hard lenses \$75</td> <td style="text-align: center;">Soft lenses \$125</td> <td style="text-align: center;">Extended wear \$175</td> </tr> </table>	Hard lenses \$75	Soft lenses \$125	Extended wear \$175
Hard lenses \$75	Soft lenses \$125	Extended wear \$175		
ELECTIVE Professional fees & materials	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Hard lenses \$75</td> <td style="text-align: center;">Soft lenses \$125</td> <td style="text-align: center;">Extended wear \$175</td> </tr> </table>	Hard lenses \$75	Soft lenses \$125	Extended wear \$175
Hard lenses \$75	Soft lenses \$125	Extended wear \$175		
FRAMES	Up to \$30 No cost Over \$30 usual, customary & reasonable fee less the \$30 Copay			
MONTHLY COSTS Employee Only Employee + 1 Employee + 2 or more	<table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: right;">\$ 6.99</td> </tr> <tr> <td style="text-align: right;">\$12.29</td> </tr> <tr> <td style="text-align: right;">\$18.33</td> </tr> </table>	\$ 6.99	\$12.29	\$18.33
\$ 6.99				
\$12.29				
\$18.33				

*May be subject to \$10 deductible if not already satisfied

**Lenses are available every 24 months if, needed. Prescription sunglasses in lieu of clear prescription glasses are also available under all programs.

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VOLUNTARY LIFE INSURANCE

Life Insurance provides protection for your beneficiary in the event of your death.



RELIANCE STANDARD SCHEDULE OF BENEFITS

VOLUNTARY TERM LIFE

EMPLOYEE BENEFIT		Maximum benefit of \$500,000	
EMPLOYEE GUARANTEE ISSUE UNDER AGE 60		\$100,000	
SPOUSAL BENEFIT		Multiple of \$10,000 to \$500,000	
SPOUSE GUARANTEE ISSUE		None	
CHILD(REN)		\$2,000/\$5,000/\$7,500/\$10,000	
REDUCTION FORMULA		Begins at age 75	
COST/AGE	SMOKER		NON-SMOKER
	Rate Per \$10,000		
Under 20	\$ 0.85		\$ 0.51
20 - 24	\$ 1.05		\$ 0.63
25 - 29	\$ 1.28		\$ 0.76
30 - 34	\$ 1.88		\$ 0.94
35 - 39	\$ 2.47		\$ 1.18
40 - 44	\$ 3.87		\$ 1.80
45 - 49	\$ 6.70		\$ 3.10
50 - 54	\$11.16		\$ 5.29
55 - 59	\$15.84		\$ 8.43
60 - 64	\$20.05		\$12.15
65 - 69	\$28.66		\$19.36
70+	\$58.81		\$42.92
Dependent Life (one rate for all) 6 months to under Age 20		\$ 0.42 for \$ 2,500 \$ 0.82 for \$ 5,000 \$ 1.22 for \$ 7,500 \$ 1.62 for \$10,000	

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