

# Employee Medical Summary



**Client Name:** Issam Tina Solutions

**Benefit Class:** 9 General Employees Southern California

**Effective Period:** 01/01/2023 -12/31/2023

New Employee Waiting Period: 1st of the month following 0 days

		MNATHSA60	KHMOSCA4	MNATHSA40	EPONAT68	KHMOSCA1	MNAT2080
		AETNA MCPOS HSA-6000-100	KAISER DHMO 4500-60 SCA	AETNA OA MCPOS HDHP 4000-100	AETNA EPO 6350-80	KAISER DHMO 1000-70 SCA	AETNA MCPOS 2000-80
<b>In Network</b>							
<b>Deductible</b>	Individual	\$6,000.00	\$4,500.00	\$4,000.00	\$6,350.00	\$1,000.00	\$2,000.00
	Family	\$12,000.00	\$9,000.00	\$8,000.00	\$12,700.00	\$2,000.00	\$4,000.00
<b>Member Co-Insurance %</b>		0%	40%	0%	20%	30%	20%
<b>Primary Care/ Specialist</b>		\$30 copay after deductible/\$60 copay after deductible	\$50 copay	\$30 copay after deductible/\$60 copay after deductible	\$40 copay/\$80 copay	\$30/\$50 copay	\$30 copay \$60 copay
<b>Xrays &amp; Laboratory Tests/ Complex Imaging</b>		0% after deductible	40% after deductible	0% after deductible	20% after deductible/No Cost/20% after deductible	\$10 copay/30% up to \$150	20% after deductible
<b>Urgent Care</b>		\$85 after deductible	\$50 copay	\$85 after deductible	\$85 copay	\$30 copay	\$85 copay
<b>Hospital Emergency Room</b>		\$350 after deductible	\$250 after deductible	\$350 after deductible	\$350 copay	30% after deductible	\$350 copay
<b>Inpatient Hospital</b>		\$500 after deductible	40% after deductible	\$500 after deductible	20% after deductible	30% after deductible	20% after deductible
<b>Outpatient Hospital</b>		\$300 after deductible	40% after deductible	\$300 after deductible	20% after deductible	30% after deductible	20% after deductible
<b>Prescription</b>		Medical ded applies, waived for preventative medications \$3/\$10/45/70/30% (\$300 Max )/ 50% (\$500 Max)	\$250 deductible* (waived for generic)/\$15/\$35/\$35/20% coinsurance up to \$250	Medical ded applies, waived for preventative medications \$3/\$10/45/70/30% (\$300 Max)/50% (\$500 Max)	\$3/\$10/45/70/30% (\$300 Max)/50% (\$500 Max)	\$125 deductible (waived for generic)/\$15/\$50/\$50/\$50	\$3/\$10/45/70/30% (\$300 Max)/50% (\$500 Max)
<b>Out of Pocket Max: Individual</b>		\$6,750	\$6,000	\$7,000	\$7,350	\$5,000	\$6,850
<b>Family</b>		\$13,500	\$12,000	\$14,000	\$14,700	\$10,000	\$13,700
<b>Out of Network</b>							
<b>Individual/Family Deductible</b>		\$12,000 (2x)	Not Applicable	\$8,000 (2x)	Not Applicable	Not Applicable	\$6,000 (2.5x)
<b>Member Co-Insurance %</b>		50%	Not Applicable	50% after deductible	Not Applicable	Not Applicable	50%
<b>Max Out of Pocket Ind/Family</b>		\$15,000(2x)	Not Applicable	\$14,000 (2x)	Not Applicable	Not Applicable	\$14,000 (3x)
<b>MONTHLY PREMIUMS</b>							
<b>Employee Only</b>		\$232.92	\$250.58	\$262.26	\$275.54	\$422.57	\$488.09
<b>Employee and Spouse</b>		\$798.05	\$835.64	\$861.14	\$890.48	\$1,214.09	\$1,358.74
<b>Employee and Child(ren)</b>		\$703.95	\$738.12	\$761.51	\$788.08	\$1,082.17	\$1,213.73
<b>Employee and Family</b>		\$1,220.92	\$1,274.43	\$1,310.59	\$1,352.10	\$1,807.70	\$2,010.77

**Find participating providers at:** [www.aetna.com/docfind](http://www.aetna.com/docfind)

Note: some plans are only available in certain areas. Please use the Engage online benefit enrollment application to see the specific plans available to you. Information presented here is for comparison purposes. If the information here is different than what is shown in the policy certificate, the certificate will prevail.

# Employee Medical Summary



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**Benefit Class:** 9 General Employees Southern California

**Effective Period:** 01/01/2023 -12/31/2023

New Employee Waiting Period: 1st of the month following 0 days

		KHMOSCA03
		KAISER HMO 0-100 30/50 SCA
<b>In Network</b>		
<b>Deductible</b>	Individual	\$0.00
	Family	\$0.00
Member Co-Insurance %		0%
	Primary Care/ Specialist	\$30/50 copay
	Xrays & Laboratory Tests/ Complex Imaging	No Cost
	Urgent Care	\$30 copay
	Hospital Emergency Room	\$100 copay
	Inpatient Hospital	\$500 per admission
	Outpatient Hospital	\$200 per procedure
	Prescription	\$15/\$35/\$35/20% up to \$250
Out of Pocket Max:	Individual	\$3,000
	Family	\$6,000
<b>Out of Network</b>		
	Individual/Family Deductible	Not Applicable
	Member Co-Insurance %	Not Applicable
	Out of Pocket Max	Not Applicable
<b>Monthly Benefit Premium</b>		
	Employee Only	\$542.19
	Employee and Spouse	\$1,477.25
	Employee and Child(ren)	\$1,321.41
	Employee and Family	\$2,178.53

**Find participating providers at:** [www.aetna.com/docfind](http://www.aetna.com/docfind)

Note: some plans are only available in certain areas. Please use the Engage online benefit enrollment application to see the specific plans available to you. Information presented here is for comparison purposes. If the information here is different than what is shown in the policy certificate, the certificate will prevail.

HNO plans are network driven and only available in certain areas. If an employee resides outside a network, they will not be offered HNO plans.

# Employee Dental Benefits Summary



**Client Name:** Issam Tina Solutions

**Benefit Class:** 9 General Employees Southern California

**Effective Period:** 01/01/2023 -12/31/2023

New Employee Waiting Period: 1st of the month following 0 days

		METLIFE MEDIUM R1	METLIFE LOW2 DPPO R1	METLIFE HIGH DPPO R1
		MDPOMR1	MDPOL2R1	MDPOHR1
<b>In Network</b>				
<b>Deductible</b>	Individual	\$50	\$50	\$50
	Family	\$150	\$150	\$150
<b>Individual Calendar Year Maximum</b>		\$2000	\$1000	\$4000
Type A - Preventive		Covered 100%	Covered 100%	Covered 100%
Type B - Restorative		Covered 80%	Covered 70%	Covered 80%
Type C - Major Restorative		Covered 50%	Covered 40%	Covered 50%
Type D- Orthodontia		Children < 26	Children < 26	Children < 26
Orthodontia Lifetime Maximum		\$1,000 per Child Only to age 26	\$1,000 per Child Only to age 26	\$1,500 per Child Only to age 26
<b>Out of Network</b>				
<b>Deductible</b>	Individual	\$50	\$50	\$50
	Family	\$150	\$150	\$150
<b>Individual Calendar Year Maximum</b>		\$2000	\$1000	\$4000
Type A - Preventive		Covered 100%	Covered 100%	Covered 100%
Type B - Restorative		Covered at 80%; you pay 20% of the PDP negotiated rate	Covered at 70%; you pay 30% of the PDP negotiated rate	Covered at 80%; you pay 20% R&C/amounts
Type C - Major Restorative		Covered at 50%; you pay 50% R&C amounts for amounts > R&C	Covered at 40%; you pay 60% of the PDP negotiated rate	Covered at 50%; you pay 50% R&C amounts
Type D- Orthodontia		Children < 26	Children < 26	Children < 26
Orthodontia Lifetime Maximum		\$1,000 per Child Only to age 26	\$1,000 per Child Only to age 26	\$1,500 per Child Only to age 26
<b>Monthly Premiums</b>				
Employee Only		\$32.84	\$22.98	\$45.23
Employee and Spouse		\$66.91	\$46.84	\$92.04
Employee and Child(ren)		\$74.92	\$52.45	\$104.88
Employee and Family		\$116.79	\$81.76	\$162.77

Note: some plans are only available in certain areas. Please use the Engage online benefit enrollment application to see the specific plans available to you. Information presented here is for comparison purposes. If the information here is different than what is shown in the policy certificate, the certificate will prevail.

# Employee Vision Benefits Summary

**Client Name:** Issam Tina Solutions  
**Benefit Class:** 9 General Employees Southern California  
**Effective Period:** 01/01/2023 -12/31/2023  
 New Employee Waiting Period: 1st of the month following 0 days

MVSP1	METLIFE VSP OPTION 1		METLIFE VISION HIGH OPTION 2	
	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK
<b>Exam</b> <i>(once every 12 rolling months)</i>				
Routine Comprehensive Eye Exam	\$10 Copay	\$45 reimbursement	\$10 Copay	\$45 reimbursement
<b>Eyeglass Lenses/Lens options</b> <i>(once every 12 rolling months)</i>				
Single vision lenses	\$20 copay	\$30 reimbursement	\$10 copay	\$30 reimbursement
Bifocal vision lenses	\$20 copay	\$50 reimbursement	\$10 copay	\$50 reimbursement
Trifocal vision lenses	\$20 copay	\$65 reimbursement	\$10 copay	\$65 reimbursement
Lenticular vision lenses	\$20 copay	\$100 reimbursement	\$10 copay	\$100 reimbursement
UV treatment	\$20 copay	No discount	\$0 copay	No discount
<b>Contact Lenses</b> <i>(once every 12 rolling months)</i>				
Conventional contact lenses	\$60 maximum copay	No Discount	\$60 maximum copay	No Discount
Elective contact lenses	\$150 allowance	\$105 reimbursement	\$180 allowance	\$105 reimbursement
Medically necessary contact lenses	\$20 copay	\$210 reimbursement	\$20 copay	\$210 reimbursement
<b>Frames</b> <i>(once every 12 rolling months)</i>				
Frame allowance	\$150 after \$20 copay + additional 20% off balance over allowance	\$70 reimbursement	\$180 allowance, \$200 allowance on featured frames. Costco, Walmart, Sam's Club \$100 allowance	\$70 reimbursement
<b>Discounts</b> <sup>1,2</sup>				
Additional pairs of eyeglasses or prescription sunglasses.	20% off retail	No Discount	20% off retail	No Discount
Laser vision correction	15% off retail or 5% off promotional price	No Discount	15% off retail or 5% off promotional price	No Discount
<b>MONTHLY PREMIUMS</b>				
Employee Only	\$9.26		\$12.29	
Employee and Spouse	\$19.29		\$25.61	
Employee and Child(ren)	\$18.10		\$24.02	
Employee and Family	\$30.79		\$40.88	

Note: some plans are only available in certain areas. Please use the Engage online benefit enrollment application to see the specific plans available to you. Information presented here is for comparison purposes. If the information here is different than what is shown in the policy certificate, the certificate will prevail.

<sup>1</sup> Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.

<sup>2</sup> Discounts apply to purchases made after the plan allowances have been exhausted.

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Control Group: 210013

**Plan Information**



**Voluntary Life and Accidental Death & Dismemberment Insurance**

Term Life Insurance plus AD&D coverage that pays benefits to you or your beneficiary(ies) if you die or are injured. Guaranteed issue at initial eligibility. Subject to evidence of insurability is not elected at initial enrollment.

This is optional coverage you may elect and pay for.

Voluntary life insurance offered in \$10,000 increments with a \$10,000 minimum for employee coverage & \$5,000 minimum for spouse. Evidence of Insurability (EOI) required for employee coverage over \$300,000 and spouse coverage over \$50,000. Will preparation services are included with supplemental life plans

**If you are age 65 or older the amounts of your life insurance will be limited based on the table below.**

Age 65-69 Percentage of full coverage reduces to 65%

Age 70+ Percentage of full coverage reduces to 50%

Age

	Employee	Spouse
Less than 30	\$0.1018	\$0.0976
Age 30-34	\$0.1249	\$0.1196
Age 35-39	\$0.1375	\$0.1312
Age 40-44	\$0.1501	\$0.1427
Age 45-49	\$0.2099	\$0.2005
Age 50-54	\$0.3065	\$0.2918
Age 55-59	\$0.5457	\$0.5195
Age 60-64	\$0.8365	\$0.7976
Age 65-69	\$1.5554	\$1.4819
70+	\$2.9155	\$2.7770

Rates shown per \$1,000 of coverage

Child Life Coverage

Cost shown is per coverage level per employee per month

Coverage Level	\$2,500	\$5,000	\$7,500	\$10,000
Cost	\$0.73	\$1.45	\$2.18	\$2.91

MSLIFE1-METLIFE SUPP LIFE & ADD



**Voluntary Short Term Disability Insurance**

Insurance that replaces a percentage of your income if you experience a temporary injury or illness that prevents you from working. Guaranteed issue at initial eligibility. Subject to evidence of insurability is not elected at initial enrollment.

This is optional coverage you may elect and pay for.

Age on Date of Your Disability	Rate	
Age 0-44	\$0.4355	<i>Rates per \$10 of covered volume. Employee paid benefit</i>
Age 45-45	\$0.4544	
Age 46-46	\$0.4628	
Age 47-47	\$0.4723	
Age 48-48	\$0.4901	
Age 49-49	\$0.5174	
Age 50-50	\$0.5352	
Age 51-51	\$0.5541	
Age 52-52	\$0.5720	
Age 53-53	\$0.6171	
Age 54-54	\$0.6633	
Age 55-55	\$0.6990	
Age 56-56	\$0.7451	
Age 57-57	\$0.7819	
Age 58-58	\$0.8092	
Age 59-59	\$0.8365	
Age 60-60	\$0.8637	
Age 61-61	\$0.8910	
Age 62-62	\$0.9089	
Age 63-63	\$0.9278	
Age 64-64	\$0.9362	
Age 65-99	\$0.9540	

MVSTD1P-METLIFE VOL STD - 7/7/26 - \$1500 @ 60%



**Voluntary Short Term Disability Insurance for California Residents**

Insurance that replaces a percentage of your income if you experience a temporary injury or illness that prevents you from working .

This is optional coverage you may elect and pay for.

Age on Date of Your Disability	Rate	
Age 0-24	\$0.0273	<i>Rates per \$10 of covered volume. Employee paid benefit; no employer contribution required.</i>
Age 25-29	\$0.0283	
Age 30-34	\$0.0294	
Age 35-39	\$0.0262	
Age 40-44	\$0.0283	
Age 45-49	\$0.0346	
Age 50-54	\$0.0430	
Age 55-59	\$0.0525	
Age 60-64	\$0.0619	
Age 65-99	\$0.0745	

MVSTDCA2P1-METLIFE VOL STD - P OPT 2 CA 7/7/26 - \$1500 @ 60%



**Voluntary Long Term Disability Insurance**

*Insurance that replaces a percentage of your income if you experience an injury or illness that prevents you from working for an extended period of time.  
Guaranteed issue at initial eligibility. Subject to evidence of insurability is not elected at initial enrollment .*

This is optional coverage you may elect and pay for

Voluntary Long Term Disability Coverage	
Age 0-24	\$0.1921
Age 25-29	\$0.2823
Age 30-34	\$0.3957
Age 35-39	\$0.5531
Age 40-44	\$0.7451
Age 45-49	\$1.1408
Age 50-54	\$1.5354
Age 55-99	\$2.0329

*Rates per \$100 of covered volume.  
Employee paid benefit*

BENEFIT DURATION: The later of Your Normal Retirement Age as defined by Social Security or the period shown here:

Age on Date of Your Disability	Benefit
less than 60	to age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

MVLTD1P-METLIFE VOL LTD - 180 EP - \$10,000 @ 60%

### MetLife Supplemental Insurance Plans

Guaranteed Issue - fixed dollar indemnity benefits



#### Accident Insurance

This is optional coverage you may elect and pay for

24 hour - Accident only coverage for ER, Doctors visits, Hospital and ICU stays, MRI/CT, ambulance, accidental death and dismemberment.

MONTHLY PREMIUMS	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Group Accident	\$14.15	\$26.19	\$23.97	\$36.01

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#### Critical Illness Insurance

This is optional coverage you may elect and pay for

**\$10,000 Non Tobacco:** Pays lump sum benefit when diagnosed with a heart attack, cancer, or any other covered condition. Spouse and Children are covered at 50% of the employee benefit amount.

MONTHLY PREMIUMS	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Age <35 (Non-Tobacco)	\$4.09	\$6.09	\$5.14	\$7.14
Age 35-49 (Non-Tobacco)	\$9.24	\$14.06	\$10.39	\$15.22
Age 50-59 (Non-Tobacco)	\$19.31	\$29.81	\$20.47	\$30.96
Age 60-64 (Non-Tobacco)	\$29.60	\$45.86	\$30.75	\$47.02
Age 65-69 (Non-Tobacco)	\$36.73	\$57.09	\$37.89	\$58.14
Age 70+ (Non-Tobacco)	\$45.55	\$70.53	\$46.70	\$71.68

**\$10,000 Tobacco:** Pays lump sum benefit when diagnosed with a heart attack, cancer, or any other covered condition. Spouse and Children are covered at 50% of the employee benefit amount.

MONTHLY PREMIUMS	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Age <35 (Tobacco)	\$6.19	\$9.13	\$7.24	\$10.29
Age 35-49 (Tobacco)	\$15.74	\$23.93	\$16.90	\$24.98
Age 50-59 (Tobacco)	\$33.90	\$52.27	\$35.05	\$53.42
Age 60-64 (Tobacco)	\$52.06	\$80.81	\$53.21	\$81.97
Age 65-69 (Tobacco)	\$64.65	\$100.44	\$65.80	\$101.59
Age 70+ (Tobacco)	\$79.45	\$123.32	\$80.60	\$124.47

EE





**Critical Illness Insurance**

This is optional coverage you may elect and pay for

**\$20,000 Non Tobacco** : Pays lump sum benefit when diagnosed with a heart attack, cancer, or any other covered condition. Spouse and Children are covered at 50% of the employee benefit amount.

MONTHLY PREMIUMS	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Age <35 (Non-Tobacco)	\$8.19	\$12.17	\$10.29	\$14.27
Age 35-49 (Non-Tobacco)	\$18.47	\$28.13	\$20.78	\$30.44
Age 50-59 (Non-Tobacco)	\$38.62	\$59.61	\$40.93	\$61.92
Age 60-64 (Non-Tobacco)	\$59.19	\$91.73	\$61.50	\$94.04
Age 65-69 (Non-Tobacco)	\$73.47	\$114.19	\$75.77	\$116.28
Age 70+ (Non-Tobacco)	\$91.10	\$141.05	\$93.41	\$143.36

**\$20,000 Tobacco** : Pays lump sum benefit when diagnosed with a heart attack, cancer, or any other covered condition. Spouse and Children are covered at 50% of the employee benefit amount.

MONTHLY PREMIUMS	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Age <35 (Tobacco)	\$12.38	\$18.26	\$14.48	\$20.57
Age 35-49 (Tobacco)	\$31.49	\$47.86	\$33.79	\$49.96
Age 50-59 (Tobacco)	\$67.80	\$104.53	\$70.11	\$106.84
Age 60-64 (Tobacco)	\$104.11	\$161.62	\$106.42	\$163.93
Age 65-69 (Tobacco)	\$129.30	\$200.87	\$131.61	\$203.18
Age 70+ (Tobacco)	\$158.89	\$246.63	\$161.20	\$248.94

EE



**Group Hospital Indemnity**

Pays benefits to help employees with higher out-of-pocket medical expenses for Hospital - ICU, doctors visits, surgery, anesthesia, and ambulance for any reason - sickness or accident.

MONTHLY PREMIUMS	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
<b>High Plan</b>	\$39.83	\$74.49	\$62.84	\$99.83
<b>Highest Plan</b>	\$61.58	\$126.86	\$105.30	\$170.58

EE



**Pet Insurance**

Pet parents can select from a range of annual limits, deductibles and coinsurance levels

No initial exam

Payroll deducted

Each pet's premium will be unique based on the age, breed, location and gender, as well as what coverage amount you select.

You may request a quote anytime by visiting the website

<https://www.metlife.com/insurance/>

## Flexible Spending Accounts

### Section 125/Health Savings/Commuter Benefits

*Grace Period- Employees have from 1/1/23 – 3/15/23 to incur claims and use their previous plan year dollars*

2023 FSA Maximums: Health FSA \$3,050; Dependent FSA \$5,000

2023 Health Savings Account Max: Individual \$3,650, Family \$7,750

2023 Commuter Benefits (monthly): Parking \$300, Transit \$300

"Stackable" Debit Card, daily claims processing & Reimbursements

Run out period 90 days from date of employee termination

24/7 Online account access and claim filing

<b>General Health FSA:</b>	Qualified Medical, Rx, Dental and Vision Expenses
<b>Limited Health FSA:</b>	Qualified H.S.A Compatible Expenses
<b>Dependent Care FSA:</b>	Qualified Daycare Expenses for Children < Age 13
<b>Transit &amp; Parking FSA:</b>	Commuter Transit Benefit

*\*Availability of these plans may vary by employer*

*Note: Previous year participants must actively enroll during open enrollment for the new plan year starting January 1st. Please use the Engage Benefit Enrollment Application to make your elections.*



This is optional coverage you may elect and pay for

**Pet Assure Veterinarian Discount Plan**  
Available to any pet

**PETPlus Discount Plan**  
Available only to cats and dogs

Covers all veterinary services	\$9.00 Unlimited pets	
Covers prescriptions, preventatives and more at wholesale pricing.	\$4.50 Single cat or dog	\$8.50 Unlimited cats & dogs

# Employee Supplemental Benefit Plans



**L LegalShield**  
 Online, Telephonic and In-Office Services (Network Attorneys)

**I IDShield**  
 Credit Monitoring, Identity Restoration, and more

This is optional coverage you may elect and pay for

MONTHLY PREMIUMS	Employee	Employee, Spouse /Significant Other & Children 18 and younger
<i>Legal Plan Services</i>	\$15.95	\$15.95
<i>ID Theft Protection</i>	\$8.45	\$15.95
<i>Both Plans (Legal &amp; ID Theft)</i>	\$24.40	\$28.90

**MEDICARE TRANSITION SERVICES** *Medicare Transition Services*

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