

Health Insurance Renewal for:
Specialized Youth Services of Virginia, Inc.
Plan Year December 1, 2014 – November 30, 2015



Brought to you by:



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Specialized Youth Services of Virginia, Inc.
Employee Benefit Offerings 2014-2015
 Rates are based on a 26 pay period year

Health Insurance **Coventry Health Care of Virginia**

VALUE POS PLAN 30/50/20% \$1000 DEDUCTIBLE

\$1000 Deductible

| | | |
|---|---------------|----------|
| \$30 Primary Care Visit | EE Only | \$121.82 |
| \$50 Specialist Visit | EE + Sp | \$367.97 |
| Inpatient Hospital – 20% after Deductible | EE + Child | \$228.88 |
| \$3/\$10/\$40/\$75 Rx Benefits | EE + Children | \$357.35 |
| \$3500/\$7000 Out of Pocket Maximum | EE + Family | \$592.89 |

SJ POS \$1000 Deductible

| | | |
|--|-------------|----------|
| \$20 Primary Care Visit | EE Only | \$113.25 |
| \$50 Specialist Visit after Deductible | EE + Sp | \$349.63 |
| Inpatient Hospital – 20% after Deductible | EE + Child | \$206.79 |
| \$3/\$10/ After Deductible \$40/\$70 Rx Benefits | EE Children | \$339.35 |
| \$6300/\$12,700 Out of Pocket Maximum | EE + Family | \$565.46 |

SJ POS \$2000 Deductible

| | | |
|---|---------------|----------|
| \$20 Primary Care Visit | EE Only | \$83.49 |
| \$50 Specialist after Deductible | EE + Sp | \$285.66 |
| Single Employee has a \$2000 DEDUCTIBLE | EE + Child | \$171.40 |
| Employee w/ Dependents – \$4000 DEDUCTIBLE | EE + Children | \$276.88 |
| Rx Benefit \$3/\$10 Not Subject to Deductible | | |
| \$40/\$75 Subject to Deductible | EE + Family | \$470.26 |

Life Insurance

Principal Financial

| | |
|-------------|----------------------|
| \$10,000.00 | 100% Paid for by SYS |
|-------------|----------------------|

Short Term Disability

Principal Financial

| | |
|---|----------------------|
| 90 day benefit period | |
| 60% of salary capped at \$500/wk | 100% Paid for by SYS |
| 1 day accident, 8 day sickness elimination period | |

Long Term Disability

Principal Financial

| | |
|------------------------------------|--------------------------------|
| 90 Day Elimination Period | |
| Picks up where MetLife Stops | Rates vary by age and income |
| Pays to age 65 | in 5 year bands...30-34, 35-39 |
| 60% of salary, Capped at \$500/wk. | |

Dental Insurance

PPO Plan

Principal Financial

| | | | | |
|-----------------------|---|----------------|---------------------|----------------|
| Type of Service | In Network | Out of Network | | |
| Preventative | 100% | 100% | EE Only | \$14.93 |
| Basic | 80% | 80% | EE + 1 | \$29.24 |
| Major | 50% | 50% | EE 2 or more | \$47.17 |
| Cal Yr Maximum | \$1250 | \$1000 | | |
| Deductible | No Deductible In Network at all. Out of Network there is a \$25 Deductible | | | |

Per Person \$50 Max Per Family for all Services including Preventative



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Supplemental Health Insurance **American Heritage Life**

| | Age | Single | Family |
|--|-------|---------|---------|
| Initial Hospital Benefit (\$500) | 18-35 | \$13.29 | \$35.53 |
| Daily Hospital Benefit (\$50 a day) | 36-49 | \$14.81 | \$38.58 |
| Outpatient Physician (\$50 2 visits a year) | 50-59 | \$17.77 | \$42.23 |
| Outpatient Emergency Accident (\$100 per 2 times a year) | 60-64 | \$22.15 | \$47.82 |

Accident Expense Plan **American Heritage Life**

| | Single | Family |
|----------------------------------|---------|---------|
| 600/mo. Disability benefit | \$11.94 | \$19.23 |
| Medical Fee reimbursement | | |
| \$100/day Hospital reimbursement | | |

Cancer Expense Plan **American Heritage Life**

| | Basic Plan | |
|-------------------------|-------------------|---------|
| | Single | Family |
| 100% Transportation | \$8.87 | \$14.96 |
| Initial Diagnosis | | |
| Specified Diseases (20) | | |

Heart/Stroke Insurance **American Heritage Life**

| | Single | Family |
|--|--------|---------|
| Pays additional benefits To insured's in the event of a Heart/Stroke episode | \$8.75 | \$16.45 |

Life Insurance **American Heritage Life**

| | |
|-------------------------------|------------|
| * Permanent Life Insurance | Rates Vary |
| * 20-Year Term Life Insurance | |

401K Retirement Plan **The Hartford**

Save up to 15% of gross income
Eligible after 6 months of continuous employment

Section 125 Administration **The Capitol Group**

Allows for the pretaxing of Qualified premiums. No Cost

**MUST BE COMPLETED REGARDLESS IF ENROLLING IN ANY PLAN OR NOT
SPECIALIZED YOUTH SERVICES OF VIRGINIA, INC.**

PAYROLL ALLOTMENT FORM

Dental and the Non-Qualified LTD Benefit run March 1, 2014 – Feb 28, 2015. The Health Insurance Runs Dec 1, 2014 – Nov. 30, 2015 as well as all the other coverages listed below.

| | |
|--------------------------|--------------------------------------|
| Employee Name: _____ | SSN#: _____ - _____ - _____ |
| Address: _____ | City _____ |
| State: _____ | Zip Code: _____ Date of Birth: _____ |
| Home Phone Number: _____ | Date of Hire: _____ |
| Salary: _____ | |

Qualified Benefit election for Salary Reduction – I elect to allocate the following amounts on a Per Pay Period Basis to the purchase of the benefits below. These include the policy premiums and all additional fees incurred.

| | Value Plan | SJ 1000 | SJ 2000 |
|-------------------|------------|------------------------|-----------------|
| Group Medical | \$ _____ | \$ _____ | \$ _____ |
| Dental Insurance | \$ _____ | Life Insurance | \$ _____ |
| Accident Coverage | \$ _____ | Heart/Stroke Insurance | \$ _____ |
| Cancer Insurance | \$ _____ | Shop Plan | \$ _____ |
| | | Total | \$ _____ |

| | | |
|------------------------------|------------|-----------------|
| NON QUALIFIED BENEFIT | LTD | \$ _____ |
|------------------------------|------------|-----------------|

I authorize my employer to reduce my paycheck by the total benefit amounts shown above. I have read and understand that all rates shown above include all administrative, billing and policy fees. Furthermore I acknowledge that if I do not submit all needed paperwork by the 15th of the month – it may delay processing of my enrollment for the first of the month following.

Date _____ **Signature** _____

| | |
|--|-----------------|
| Waiver of Participation | |
| IF YOU DECLINE PARTICIPATION: The benefits of the plan have been thoroughly explained to me and after careful consideration, I have elected NOT to take advantage of this offer and understand that I am now ineligible to participate until December 2015, which coincides with open enrollment for Specialized Youth Services of VA, Inc. | |
| Date _____ | Signature _____ |