Group Insurance Proposal

Date Prepared: January 13, 2011

Quote # 973147-1.10 Zip Code: 92618

SIC Code: 5999 - MISC. RETAIL STORES, NEC

Prepared for

PHAT PLANET MUSIC INC.

Presented By:

RABINDER SEKHON

SEKHON ADVISORS

(310) 482-1282

License No. 0F28693

These rates were quoted for the proposed effective date of 02/01/11. If another effective date is selected or you are requesting an effective date more than 30 days in advance please confirm the rates quoted.

CaliforniaChoice®

Your Health. Your Choice.®

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Finally, Everyone Gets What They Want!

California*Choice*® is the only program in the state that offers **five health plans** in one program. And, it's easier to implement and administer than any single health plan.

What does this mean for my employees?

Each employee has the freedom to choose his or her own health plan, benefit design and monthly cost. This eliminates the hassle of you having to choose one health plan for all of your employees!

Is it easy to implement?

Yes! Everything from enrollment to renewal is managed through us. We're just as easy to manage as if you were working with a single health plan!

Sounds good, but how much?

You tell us! Through Defined Contribution you have the power to **define your own monthly contribution**, as long as it's at least 50% of the lowest cost plan.

Employees then take your contribution and apply it toward any of the health plan and benefit plan options. If, for example, an employee wants to buy-up to a higher level of benefits, they just pay the difference – it's their choice!

California*Choice* Includes:

- **5 Health Plans**
- **HMO**, PPO & Consumer Directed Plans
- **Free** Discount Dental
- **Free** Discount Vision
- **Free** Hearing Benefit
- **Free** Online HR Support
- **Free** Cal COBRA Services
- **Free** Federal COBRA Billing Services
- **Free** Access to Cal Perks Discount Center
- **Guarantee issue** life insurance
- **Additional options** for Dental, Vision, Chiropractic/ Acupuncture, Life and Section 125 benefits also available
- **Integrated** payroll services
- **12 Month Rate Guarantee**
- **You decide what you want to contribute** to employee benefits – not an insurance company
- **One monthly bill** includes both employee medical and optional benefits
- **Flexible participation requirements**; any number of employees can enroll in any plan
- **One** enrollment application
- **Live Customer Service** Monday – Friday, 8:00 am – 5:00 pm
- **Renewal specialists** available

California*Choice* is Healthcare for the way We Live®

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Your Health. Your Choice.®

CALIFORNIACHOICE PROGRAM - "BENEFIT PLANS"

HMO Plans	All eligible HMO benefits are covered In-Network only.					
Participating Health Plans	**Anthem Blue Cross*, Health Net*, Kaiser Permanente, Sharp, Western Health**	**Sharp, Western Health**	**Anthem Blue Cross*, Health Net***	**Kaiser Permanente**	**Anthem Blue Cross***	**Health Net***
In-Network	**HMO 15**	**HMO 25**	**HMO 25**	**HMO 25**	**HMO 25 Value**	**HMO 25 Value**
HMO Network Required	Yes	Yes	Yes	Yes	Yes	Yes
Deductible	No Deductible	No Deductible	No Deductible	No Deductible	$1,000/$2,000	No Deductible
Dr. Office Visits	$15 Copay	$25 Copay	$25 Copay	$25 Copay	$25 Copay	$25 Copay
Hospital Services	$400 Copay-100%	$400 Copay Per Day (Max $1,200)	$450 Copay Per Day (Max $1,800)	$400 Copay Per Admission	80% (after deductible)	75%
Rx Benefit (Generic Formulary)	$10 Copay	$15 Copay	$15 Copay	$10 Copay	$15 Copay	$15 Copay
Rx Benefit (Brand Formulary)	$20 Copay	$100 Ded-$30 Copay	$100 Ded-$30 Copay	$25 Copay	$200 Ded-$30 Copay	$100 Ded-$30 Copay
Out-Of-Pocket Max Ind/Fam	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000	$2,500/$5,000	$3,000/$6,000	$3,000/$6,000

HMO Plans (continued)	All eligible HMO benefits are covered In-Network only.				
Participating Health Plans	**Anthem Blue Cross*, Health Net*, Sharp, Western Health**	**Kaiser Permanente**	**Health Net***	**Health Net***	**Health Net**
In-Network	**HMO 30**	**HMO 30**	**HMO 30 Value**	**Elect Open Access**	**Salud**
HMO Network Required	Yes	Yes	Yes	Optional	Yes
Deductible	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible
Dr. Office Visits	$30 Copay	$30 Copay	$30 Copay	$25 HMO-$40 PPO	$25 Copay
Hospital Services	$450 Copay Per Day (Max $1,800)	$450 Copay Per Admission	70%	75%	$500 Copay Per Day (Max $1,000)
Rx Benefit (Generic Formulary)	$15 Copay	$15 Copay	$20 Copay	$15 Copay	$15 Copay
Rx Benefit (Brand Formulary)	$150 Ded-$30 Copay	$30 Copay	$200 Ded-$30 Copay	$150 Ded-$30 Copay	$25 Copay
Out-Of-Pocket Max Ind/Fam	$3,000/$6,000	$3,000/$6,000	$3,500/$7,000	$2,500/$6,000	$2,500/$5,000

HMO Plans (continued)	All eligible HMO benefits are covered In-Network only.				
Participating Health Plans	**Anthem Blue Cross*, Health Net*, Sharp, Western Health**	**Kaiser Permanente**	**Anthem Blue Cross***	**Health Net***	**Western Health**
In-Network	**HMO 40**	**HMO 40**	**HMO 40 Value**	**HMO 40 Value**	**HMO 40 Value**
HMO Network Required	Yes	Yes	Yes	Yes	Yes
Deductible	No Deductible	No Deductible	$1,500/$3,000	No Deductible	$2,500/$5,000
Dr. Office Visits	$40 Copay	$40 Copay	$40 Copay	$40 Copay	$40 Copay
Hospital Services	$500 Copay Per Day	$500 Copay Per Day	70% (after deductible)	60%	$500 Copay Per Day After Deductible
Rx Benefit (Generic Formulary)	$20 Copay	$15 Copay	$15 Copay	$20 Copay	$20 Copay
Rx Benefit (Brand Formulary)	$200 Ded-$30 Copay	$30 Copay	$250 Ded-$30 Copay	$200 Ded-$30 Copay	$250 Ded-$30 Copay
Out-Of-Pocket Max Ind/Fam	$3,500/$7,000	$3,500/$7,000	$4,000/$8,000	$3,500/$7,000	$5,000/$10,000

PPO Plans				Consumer Choice PPO Plans	
Participating Health Plans	**Anthem Blue Cross**	**Anthem Blue Cross**	**Anthem Blue Cross**	**Anthem Blue Cross**	**Anthem Blue Cross**
In-Network	**PPO 1000**	**PPO 3000**	**PPO 4000**	**Lumenos HSA 1800**	**Lumenos HSA 2500**
Network Required	No	No	No	No	No
Deductible	$1,000	$3,000	$4,000	$1,800/$3,600	$2,500/$5,000
Dr. Office Visits	$40 Copay	$30 Copay	$40 Copay	80%	80%
Hospital Services	$1,000 Copay - 70%	$500 Copay - 70%	$500 Copay - 60%	80%	80%
Rx Benefit (Generic Formulary)	$15 Copay	$15 Copay	$15 Copay	$15 Copay(after ded.)	$15 Copay(after ded.)
Rx Benefit (Brand Formulary)	$200 Ded - $30 Copay	$250 Ded - $30 Copay	$250 Ded - $30 Copay	$30 Copay(after ded.)	$30 Copay(after ded.)
Out-Of-Pocket Max Ind/Fam	$4,500/$9,000	$7,000/$14,000	$7,000/$14,000	$3,000/$5,500	$4,000/$6,000
Out-Of-Network					
Deductible	$1,000	$3,000	$4,000	$1,800/$3,600	$2,500/$5,000
Dr. Office Visits	50%	50%	50%	50%	50%
Hospital Services	Covered up to $650 Per Day	Covered up to $650 Per Day	Covered up to $650 Per Day	Covered up to $650 Per Day	Covered up to $650 Per Day
Rx Benefit (Generic Formulary)	$15 Copay	$15 Copay	$15 Copay	$15 Copay(after ded.)	$15 Copay(after ded.)
Rx Benefit (Brand Formulary)	$200 Ded - $30 Copay	$250 Ded - $30 Copay	$250 Ded - $30 Copay	$30 Copay(after ded.)	$30 Copay(after ded.)
Out-Of-Pocket Max Ind/Fam	$10,000 Per Member	$10,000 Per Member	$10,000 Per Member	$3,000/$5,500	$4,000/$6,000

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

Note: Not all plans are available in all areas.

GROUP CENSUS INFORMATION

PHAT PLANET MUSIC INC.

Employee Name	Sex	Employee D.O.B	Age	Spouse D.O.B.	Spouse Coverage	# of Children	Life Amount	EE Home Zip Code
SHAW, D	M	08/03/71	39	08/03/71	YES	0	$ 10,000	91604
D'ANDREA, M	M	02/05/68	42		NO	0	$ 10,000	92618

Total Employees = 2

SET YOUR MONTHLY HEALTHCARE BUDGET

California*Choice* makes it easy to set your budget - first, consider your monthly expenses.

How much do you want to spend?

(These are samples of what we hear many of our satisfied customers say.)

- I want to pay exactly what I'm paying today.
- I need to stay under a certain amount each month.
- I want to pay the least I can and still offer my employees the best.
- I want to cover all of my employees' costs, but not their dependents.
- I don't want to spend the most, but I don't want to spend the least – something in the middle.
- I don't want my employees to pay for a thing – I'll cover it.

The monthly premiums outlined below are an example based on contributing a **FIXED PERCENTAGE** of employee premium. You also have the option to simply contribute a **FIXED DOLLAR AMOUNT** for each employee, and/or their dependent to use toward any of our benefit plan options.

Premiums include: 2 Employees and 1 Dependent Unit

Lowest Cost Plan Available: *	Total Employee Premium	Total Dependent Premium	Total Group Premium	Net Cost To Employer at: 50% EE 0% DEP	75% EE 0% DEP	____% EE ____% DEP
HMO Plans **						
HMO 40 Value	$ 611	$ 315	$ 926	$ 306	$ 458	________
HMO 40	$ 620	$ 492	$ 1,112	$ 310	$ 465	________
HMO 30 Value	$ 777	$ 404	$ 1,181	$ 388	$ 583	________
HMO 30	$ 655	$ 520	$ 1,175	$ 327	$ 491	________
HMO 25 Value	$ 812	$ 440	$ 1,252	$ 406	$ 609	________
HMO 25	$ 683	$ 542	$ 1,225	$ 341	$ 512	________
HMO 15	$ 1,008	$ 801	$ 1,809	$ 504	$ 756	________
HMO Plans ** (Using Anthem Blue Cross Select HMO and Health Net Silver Network)						
HMO 40 Value	$ 558	$ 317	$ 875	$ 279	$ 418	________
HMO 40	$ 614	$ 366	$ 980	$ 307	$ 461	________
HMO 30 Value	$ 688	$ 355	$ 1,044	$ 344	$ 516	________
HMO 30	$ 655	$ 520	$ 1,175	$ 327	$ 491	________
HMO 25 Value	$ 703	$ 387	$ 1,090	$ 351	$ 527	________
HMO 25	$ 677	$ 403	$ 1,080	$ 338	$ 507	________
HMO 15	$ 996	$ 592	$ 1,587	$ 498	$ 747	________
PPO Plans						
HSA 2500	$ 956	$ 608	$ 1,565	$ 478	$ 717	________
HSA 1800	$ 1,174	$ 747	$ 1,921	$ 587	$ 880	________
PPO 4000	$ 810	$ 511	$ 1,321	$ 405	$ 607	________
PPO 3000	$ 939	$ 592	$ 1,531	$ 469	$ 704	________
PPO 1000	$ 1,401	$ 902	$ 2,303	$ 701	$ 1,051	________

Minimum Employer Contribution

Calculate your net Cost above!

* All premiums are calculated by selecting the Health Plan which produces the best employee rate.
Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR these provider networks to their employees.
Note: Premiums do not include the ***Monthly Billing Fee*** (1-8 employees = $20; 9-20 employees = $25; 21+ employees = $30).

DEFINE YOUR CONTRIBUTION

After you determine what you want to pay each month, it's time to define your contribution.

There are two major ways to define your contribution; you can either pay a PERCENTAGE OF COST or pay a FIXED DOLLAR AMOUNT.

1. PERCENTAGE OF COST

If you've chosen to contribute a **FIXED PERCENTAGE** of cost, just take the percentage of premium you decided to pay and the benefit plan you want to apply that amount to and complete the sections below.

For example: You select **75%** of the **lowest cost HMO 30** plan or **$491** from the previous page and zero toward dependents. Your application would look like this:

❑ **OPTION 1** | **PERCENTAGE OF COST**

STEP 1: Enter the percentage amount you will contribute toward:

Employee Premium: __75__% (50% minimum) Dependent Premium: __0__% (write 0 if none)

STEP 2: Apply contribution toward one HMO, PPO or ANY Plan Option (A, B, or C)

A. ☒ **HMO:**
- ☒ Lowest cost plan in HMO benefit level:
- ❑ Highest cost plan in HMO benefit level:
- ❑ All plans in HMO benefit level:

→ ❑ 15 ❑ 25 ❑ 25 Value ☒ 30 ❑ 30 Value ❑ 40 ❑ 40 Value

- ❑ Specific Health Plan (select one from list): →

Carrier	HMO 15	HMO 25	HMO 25 Value	Elect Open Access	HMO 30	HMO 30 Value	HMO 40	HMO 40 Value
Anthem Blue Cross	❑	❑	❑		❑		❑	❑
Health Net	❑	❑	❑	❑	❑	❑	❑	❑
Kaiser Permanente	❑	❑			❑		❑	
Sharp	❑	❑			❑		❑	
Western Health Advantage	❑	❑			❑		❑	❑

B. ❑ **PPO:** ❑ 750 ❑ 1000 ❑ 3000 ❑ 4000 ❑ HSA 1800* ❑ HSA 2500*

PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE

** HSA-Qualified High Deductible Health Plan*

C. ❑ Any HMO or PPO plan selected by employee

2. FIXED DOLLAR AMOUNT

Another option is to contribute a **FIXED DOLLAR AMOUNT** toward each employee and/or their dependents.

For example: You want to contribute $150 to each employee and $0 toward dependents. Your application would look like this:

❑ **OPTION 2** | **EMPLOYER FIXED DOLLAR AMOUNT**

Enter the dollar amount you will contribute which will be applied to any plan selected by employee:

$ __150__for Employee
$ __0__for Dependents

OR

$ ________Combined amount for Employee and Dependents

California*Choice* Program

Employee Enrollment Worksheet

Effective Date: **02/01/11**
Quote #: **973147**
Employer Zip Code: **92618**

PHAT PLANET MUSIC INC.
Sample Employee - Age 39
Residence Zip Code: **91604**

HMO Plans

All eligible HMO benefits are covered In-Network only.

Participating Health Plans	Anthem Blue Cross, Health Net, Kaiser Permanente	Anthem Blue Cross, Health Net	Kaiser Permanente	Anthem Blue Cross	Health Net
In-Network	**HMO 15**[1]	**HMO 25**[1]	**HMO 25**[1]	**HMO 25 Value**	**HMO 25 Value**
HMO Network Required	Yes	Yes	Yes	Yes	Yes
Deductible	No Deductible	No Deductible	No Deductible	$1,000/$2,000	No Deductible
Dr. Office Visits	$15 Copay	$25 Copay	$25 Copay	$25 Copay	$25 Copay
Hospital Services	$400 Copay-100%	$450 Copay Per Day (Max $1,800)	$400 Copay Per Admission	80% (after deductible)	75%
Rx Benefit (Generic Formulary)	$10 Copay	$15 Copay	$10 Copay	$15 Copay	$15 Copay
Rx Benefit (Brand Formulary)	$20 Copay[2]	$100 Ded-$30 Copay[2]	$25 Copay	$200 Ded-$30 Copay[2]	$100 Ded-$30 Copay
Out-Of-Pocket Max Ind/Fam	$2,000/$4,000	$3,000/$6,000	$2,500/$5,000	$3,000/$6,000	$3,000/$6,000

HMO Plans (continued)

All eligible HMO benefits are covered In-Network only.

Participating Health Plans	Anthem Blue Cross, Health Net	Kaiser Permanente	Health Net	Health Net	Health Net
In-Network	**HMO 30**[1]	**HMO 30**[1]	**HMO 30 Value**	**Elect Open Access**	**Salud**
HMO Network Required	Yes	Yes	Yes	Optional	Yes
Deductible	No Deductible	No Deductible	No Deductible	No Deductible	No Deductible
Dr. Office Visits	$30 Copay	$30 Copay	$30 Copay	$25 HMO-$40 PPO	$25 Copay
Hospital Services	$450 Copay Per Day (Max $1,800)	$450 Copay Per Admission	70%	75%	$500 Copay Per Day (Max $1,000)
Rx Benefit (Generic Formulary)	$15 Copay	$15 Copay	$20 Copay	$15 Copay	$15 Copay
Rx Benefit (Brand Formulary)	$150 Ded-$30 Copay[2]	$30 Copay	$200 Ded-$30 Copay	$150 Ded-$30 Copay	$25 Copay
Out-Of-Pocket Max Ind/Fam	$3,000/$6,000	$3,000/$6,000	$3,500/$7,000	$2,500/$6,000	$2,500/$5,000

HMO Plans (continued)

All eligible HMO benefits are covered In-Network only.

Participating Health Plans	Anthem Blue Cross, Health Net	Kaiser Permanente	Anthem Blue Cross	Health Net
In-Network	**HMO 40**[1]	**HMO 40**[1]	**HMO 40 Value**	**HMO 40 Value**
HMO Network Required	Yes	Yes	Yes	Yes
Deductible	No Deductible	No Deductible	$1,500/$3,000	No Deductible
Dr. Office Visits	$40 Copay	$40 Copay	$40 Copay	$40 Copay
Hospital Services	$500 Copay Per Day	$500 Copay Per Day	70% (after deductible)	60%
Rx Benefit (Generic Formulary)	$20 Copay	$15 Copay	$15 Copay	$20 Copay
Rx Benefit (Brand Formulary)	$200 Ded-$30 Copay[2]	$30 Copay	$250 Ded-$30 Copay[2]	$200 Ded-$30 Copay
Out-Of-Pocket Max Ind/Fam	$3,500/$7,000	$3,500/$7,000	$4,000/$8,000	$3,500/$7,000

PPO Plans

PPO Plans				Consumer Choice PPO Plans	
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
In-Network	**PPO 1000**	**PPO 3000**	**PPO 4000**	**Lumenos HSA 1800**	**Lumenos HSA 2500**
Network Required	No	No	No	No	No
Deductible	$1,000	$3,000	$4,000	$1,800/$3,600[3]	$2,500/$5,000[3]
Dr. Office Visits	$40 Copay	$30 Copay	$40 Copay	80%	80%
Hospital Services	$1,000 Copay - 70%	$500 Copay - 70%	$500 Copay - 60%	80%	80%
Rx Benefit (Generic Formulary)	$15 Copay	$15 Copay	$15 Copay	$15 Copay(after ded.)	$15 Copay(after ded.)
Rx Benefit (Brand Formulary)	$200 Ded - $30 Copay[2]	$250 Ded - $30 Copay[2]	$250 Ded - $30 Copay[2]	$30 Copay[2](after ded.)	$30 Copay[2](after ded.)
Out-Of-Pocket Max Ind/Fam	$4,500/$9,000[4]	$7,000/$14,000[4]	$7,000/$14,000[4]	$3,000/$5,500[3][4]	$4,000/$6,000[3][4]
Out-Of-Network					
Deductible	$1,000	$3,000	$4,000	$1,800/$3,600[3]	$2,500/$5,000[3]
Dr. Office Visits	50%	50%	50%	50%	50%
Hospital Services	Covered up to $650[5] Per Day	Covered up to $650[5] Per Day	Covered up to $650[5] Per Day	Covered up to $650[5] Per Day	Covered up to $650[5] Per Day
Rx Benefit (Generic Formulary)	$15 Copay[2]	$15 Copay[2]	$15 Copay[2]	$15 Copay[2](after ded.)	$15 Copay[2](after ded.)
Rx Benefit (Brand Formulary)	$200 Ded - $30 Copay[2]	$250 Ded - $30 Copay[2]	$250 Ded - $30 Copay[2]	$30 Copay[2](after ded.)	$30 Copay[2](after ded.)
Out-Of-Pocket Max Ind/Fam	$10,000 Per Member	$10,000 Per Member	$10,000 Per Member	$3,000/$5,500[3]	$4,000/$6,000[3]

[1] Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

[2] For Anthem Blue Cross, if a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug (if applicable). The amount paid does not apply to the member's brand-name deductible. For PPO Plans, benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.

[3] Employees enrolling for single coverage must satisfy the single deductible; for employees enrolling with Dependent coverage, the family deductible must be met before any member receives benefits. The out-of-pocket maximum includes the plan deductible.

[4] The Out-of-Pocket maximum includes the plan deductible.

[5] The coverage amount listed is the maximum allowed charge for non-emergency services received from a non-participating hospital or non-participating provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.

California*Choice* Program

Employee Enrollment Worksheet

Effective Date: **02/01/11**
Quote #: **973147**
Employer Zip Code: **92618**

PHAT PLANET MUSIC INC.
Sample Employee - Age 39
Residence Zip Code: **91604**

Sample Employee, choose the benefit design and price that works best for you!

The following premiums illustrate the cost to you ***after*** your employer has made their contribution. All family members must enroll with the same Participating Plan.

Your Employer has agreed to contribute:
100 % of the Best Employee Rate for HMO Health Plan 30
0 % of the Dependent Rate for Same Plan as Above

Have we correctly listed your **Age** and **Residence Zip Code** above? ❐ **Yes** ❐ **No** (... your quoted premium may be incorrect. Please notify your Health Plan Administrator.)

In this example, the employer has chosen to contribute a percentage of the lowest-cost plan in the HMO 30 benefit level.

We have highlighted the plan that your employer has set their contribution against.

Employees are free to "buy up" or "buy down" coverage through a payroll deduction.

HMO Plans	THESE ARE YOUR COSTS PER MONTH.			
	Employee Only	Additional cost for Spouse Only	Additional cost for Child(ren) Only	Additional cost for Family
HMO 15				
Anthem Blue Cross	[illegible]	[illegible]	$ 770.45	$1,565.94
Health Net	[illegible]	[illegible]	$ 635.39	$1,333.10
Kaiser Permanente	[illegible]	[illegible]	$ 725.74	$1,347.45
HMO 25				
Anthem Blue Cross	$ 163.27	$ 563.54	$ 553.88	$1,127.14
Health Net	$ 48.92	$ 458.34	$ 433.04	$ 908.77
Kaiser Permanente	$ 12.94	$ 542.48	$ 491.61	$ 912.76
HMO 25 Value				
Anthem Blue Cross	$ 50.55	$ 427.43	$ 421.30	$ 854.82
Health Net	$ 34.84	$ 439.99	$ 415.70	$ 872.39
Elect Open Access				
Health Net	$ 83.98	$ 503.94	$ 476.14	$ 999.24
Salud				
Health Net	$ 0.00	$ [illegible]	[illegible]	$ 545.30
HMO 30				
Anthem Blue Cross	$ 65.20	$ 445.14	$ 438.76	$ 890.27
Health Net	$ 42.80	$ 450.29	$ 425.45	$ 892.86
Kaiser Permanente	$ 0.00	$ 520.22	$ 471.44	$ 875.33
HMO 30 Value				
Health Net	$ 7.08	$ 403.84	$ 381.55	$ 800.70
HMO 40				
Anthem Blue Cross	$ 25.06	$ 396.61	$ 390.91	$ 793.16
Health Net	$ 16.32	$ 415.83	$ 392.90	$ 824.55
Kaiser Permanente	$ 0.00	$ 492.45	$ 446.27	$ 828.59
HMO 40 Value				
Anthem Blue Cross	$ 0.00	$ 315.07	$ 310.56	$ 630.14
Health Net	$ 0.00	$ 360.78	$ 340.86	$ 715.35

Note: Plan availability will ... olled employees. Groups of 2-9 = All plans except PPO 750. Groups of 10+ = All plans ...

PPO Plans	Employee Only	Additional cost for Spouse Only	Additional cost for Child(ren) Only	Additional cost for Family
Anthem Blue Cross				
PPO 1000	$ 316.69	$ 901.91	$ 609.31	$1,349.44
PPO 3000	$ 104.22	$ 592.48	$ 402.31	$ 887.54
PPO 4000	$ 48.16	$ 510.98	$ 346.98	$ 765.43
HSA 1800	$ 213.29	$ 746.72	$ 507.79	$1,122.27
HSA 2500	$ 117.72	$ 608.45	$ 413.75	$ 914.46

Note: Rates are guaranteed for 12 months **unless** you have an address or an age change during the year that moves you to a new age band (i.e. changing to age 30, 40, 50, 55, 60, or 65). Final rates for employees age 65+ are subject to change and will be determined by total employee count and employee Medicare coverage. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage for detailed benefits.

California*Choice*® Program

SAMPLE INVOICE

Everything is included in One bill and paid with One check!

Invoice Number	799999
Due Date	06/20/2010
Coverage Period	JULY 2010

Premium payments will need to be received by ***June 20th*** for ***July*** coverage and should be paid as billed.
Check your next invoice for any adjustments that did not reflect on this statement.

	MEDICAL BENEFITS	DENTAL BENEFITS
Employer Contribution for Employee	100% of the Lowest Cost HMO Plan 30	FDH Access 100 included at No Charge
Employer Contribution for Dependents	0% of Same Plan as Above	FDH Access 100 included at No Charge

Employee Information	Plan Type	Coverage Selected	Health Plan	Benefit Level	Employee Premium	Dependent Premium	Total	Employer Contrib.	Employee Contrib.	EE Total Deduction	Chg Code
Beck,G	Medical	Employee	Anthem Blue Cross	40	$ 364.11	$ 0.00	$ 364.11	$ 335.88	$ 28.23		
XXX-XX-7884 45 90040	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 4.91	$ 0.00	$ 4.91	$ 4.91	$ 0.00	$ 28.23	
Davis,S	Medical	Employee	Anthem Blue Cross PPO	750	$ 716.13	$ 0.00	$ 716.13	$ 246.67	$ 469.46		
XXX-XX-4234 35 92868	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 2.15	$ 0.00	$ 2.15	$ 2.15	$ 0.00	$ 469.46	
Harris,S	Medical	Employee	Health Net	15	$ 492.49	$ 0.00	$ 492.49	$ 223.23	$ 269.26		
XXX-XX-2433 25 92868	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 1.69	$ 0.00	$ 1.69	$ 1.69	$ 0.00	$ 269.26	
Hernandez,R	Medical	Employee	Kaiser Permanente	15	$ 379.71	$ 0.00	$ 379.71	$ 246.67	$ 133.04		
XXX-XX-3445 33 92868	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 1.69	$ 0.00	$ 1.69	$ 1.69	$ 0.00	$ 133.04	
Johnson,W	Medical	EE+Spouse	Health Net	25	$ 506.88	$ 646.59	$ 1,153.47	$ 335.88	$ 817.59		
XXX-XX-8776 45 92019	Dental	EE+Spouse	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	EE+Spouse	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	EE+Spouse	Assurity Life Insurance	15000	$ 4.91	$ 0.00	$ 4.91	$ 4.91	$ 0.00	$ 817.59	
Monroe,J	Medical	Employee	Kaiser Permanente	25	$ 423.30	$ 0.00	$ 423.30	$ 407.90	$ 15.40		
XXX-XX-4300 48 95672	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 2.49	$ 0.00	$ 2.49	$ 2.49	$ 0.00	$ 15.40	
Nelson,H	Medical	EE+Spouse	Anthem Blue Cross	40 Value	$ 296.98	$ 416.55	$ 713.53	$ 286.16	$ 427.37		
XXX-XX-3444 28 95672	Dental	EE+Spouse	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	EE+Spouse	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	EE+Spouse	Assurity Life Insurance	15000	$ 1.69	$ 0.00	$ 1.69	$ 1.69	$ 0.00	$ 427.37	
Roberts,G	Medical	Employee	Health Net	15	$ 646.93	$ 0.00	$ 646.93	$ 286.16	$ 360.77		
XXX-XX-6775 28 94250	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 1.69	$ 0.00	$ 1.69	$ 1.69	$ 0.00	$ 360.77	
Rodgers,V	Medical	Employee	Anthem Blue Cross	40	$ 513.63	$ 0.00	$ 513.63	$ 437.16	$ 76.47		
XXX-XX-3889 54 92101	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 8.34	$ 0.00	$ 8.34	$ 8.34	$ 0.00	$ 76.47	
Smith,D	Medical	Employee	Sharp Health	40	$ 535.43	$ 0.00	$ 535.43	$ 535.43	$ 0.00		
XXX-XX-8765 59 92101	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 14.43	$ 0.00	$ 14.43	$ 14.43	$ 0.00	$ 0.00	
Thomas,A	Medical	Employee	Western Health	30	$ 401.92	$ 0.00	$ 401.92	$ 401.92	$ 0.00		
XXX-XX-6888 48 95814	Dental	Employee	First Dental Health	100	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00		
	Chiro	Employee	Landmark Health	110	$ 2.95	$ 0.00	$ 2.95	$ 2.95	$ 0.00		
	Life	Employee	Assurity Life Insurance	15000	$ 4.91	$ 0.00	$ 4.91	$ 4.91	$ 0.00	$ 0.00	
Late Premium payments may be assessed an additional 10% late fee.				Administration Fee†			**$ 25.00**	$ 3,824.41		$ 2,597.59	
† Administration Fee Schedule: 1-8 EE's-$20; 9-20 EE's-$25; 21+ EE's-$30				Current Month's Premium			**$ 6,447.00**				

☞ **See Premium Statement for Total Balance Due.**

Rates are guaranteed for 12 months unless an age change during the year moves an employee to a new age band (i.e. changing to age 30, 40, 50, 55, 60, or 65).

Change Codes: **A**-Add **AC**-Add Cobra **C**-Change Plan **CA**-Change Age **CE**-Change Enroll Date **CI**-Change Information **CO**-Correction **DA**-Dependent Add **DT**-Dependent Termination **ER**-Employee Reinstatement **GR**-Group Reinstatement **NT**-New Termination **RA**-Retro Add **RC**-Retro Change Plan **RDA**-Retro Dependent Add **RDT**-Retro Dependent Termination **RT**-Retro Termination **VC**-Life Volume Change

NOTE: Please verify your employer/employee contributions to ensure accuracy of employee deductions.

Sample

Comparison of HMO, Elect Open Access, PPO, and HSA Benefits

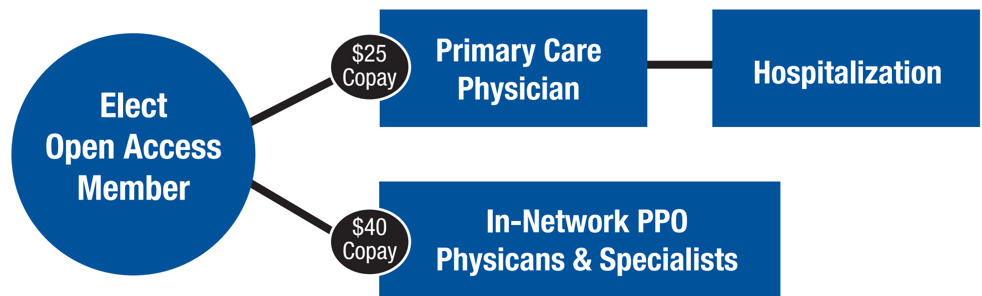
HMO Benefits

Under an HMO plan, all access to specialists and hospitalization must be determined through the member's Primary Care Physician (PCP).

Elect Open Access

(Health Net only)

Under the Elect Open Access plan, members must choose a Primary Care Physician (PCP). However, for a $40 copay, members may self-refer to any doctor in the Elect Open Access listing in the California*Choice*® Provider Directory. In-hospital benefits must be determined by a member's PCP.



PPO Benefits

(Anthem Blue Cross Life and Health Insurance Company only)

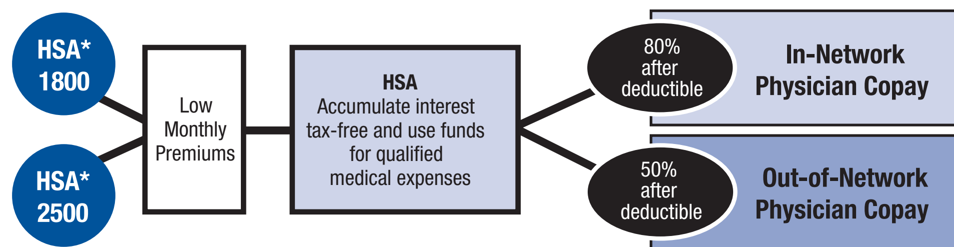
Under a PPO plan, members do not choose a Primary Care Physician (PCP). PPO members may self-refer to specialists. Members can receive care from 2 levels of in-network doctors or go out-of-network for lower benefits.

Health Savings Account (HSA) Benefits

(Anthem Blue Cross Life and Health Insurance Company only)

Members receive comprehensive medical coverage and have the option to contribute tax-deductible funds into a Health Savings Account (HSA) and accumulate tax-deferred interest. HSA members do not pay taxes on withdrawals when paying for qualified medical expenses.

*HSA - Qualified High Deductible Health Plan



California*Choice* Program

ANTHEM BLUE CROSS - HMO SUMMARY BENEFITS & FEATURES

MEDICAL BENEFITS	HMO 15*^	HMO 25*^	HMO 25 Value*
Deductible	No Deductible	No Deductible	$1,000 / $2,000 (applies to max OOP)
DR. OFFICE VISITS	**$15 Copay**	**$25 Copay**	**$25 Copay**
Lab and X-Ray	$15 Copay	No Copay	No Copay
MRI, CT, and PET	No Copay	$50 Copay	$100 Copay
HOSPITAL SERVICES	**$400 Copay - 100%**	**$450 Copay Per Day - Max $1,800**	**80%** (after deductible)
In-Patient Physician Fees	No Copay	No Copay	No Copay
Emergency Room	$100 Copay (waived if admitted)	$150 Copay (waived if admitted)	$150 Copay (after ded - waived if admitted)
RX BENEFIT - Generic	**$10 Copay**	**$15 Copay**	**$15 Copay**
- Brand Formulary ①	**$20 Copay**	**$100 Ded - $30 Copay**	**$200 Ded - $30 Copay**
Oral Contraceptives Covered	Yes	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	No Copay	No Copay
Out-of-Pocket Max - Ind/Fam	$2,000 / $4,000	$3,000 / $6,000	$3,000 / $6,000
2nd Surgical Opinion	$15 Copay	$25 Copay	$25 Copay
Out-Patient Surgery	$200 Copay	$400 Copay	80% (after deductible)
Home Health Care	No Copay	No Copay	No Copay
Skilled Nursing Facility Per Disability	$400 Copay Max 100 Days Per Year	No Copay	No Copay (after deductible)
Ambulance	$50 Per Trip	$100 Per Trip	$100 Per Trip
Pre-Existing Conditions	Covered	Covered	Covered
Mental / Nervous Severe / Non-Severe: ②③ Doctor Fees - Annual Maximum	$30 Copay 20 Visits Per Year	100% No Maximum	100% No Maximum
Hospital Fees	Not Covered	$450 Copay Per Day - Max $1,800	80% (after deductible)
Drug / Alcohol: ③ Hospital Fees	$400 Copay - 100% Acute Detox Only	$450 Copay Per Day - Max $1,800	80% (after deductible)

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug. The amount paid does not apply to the member's brand-name deductible.

② Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizophrenic disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

③ Pre-service review is required for the following mental or nervous disorders and substance abuse services: 1) Facility-based treatment or you will be required to pay a $250 Copayment if pre-service review is not obtained; and 2) Outpatient professional services after twelve visits.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

ANTHEM BLUE CROSS - HMO SUMMARY BENEFITS & FEATURES (cont.)

MEDICAL BENEFITS	HMO 30*^	HMO 40*^	HMO 40 Value*
Deductible	No Deductible	No Deductible	$1,500 / $3,000 (applies to max OOP)
DR. OFFICE VISITS	**$30 Copay**	**$40 Copay**	**$40 Copay**
Lab and X-Ray	No Copay	No Copay	No Copay
MRI, CT, and PET	$50 Copay	$50 Copay	$100 Copay
HOSPITAL SERVICES	**$450 Copay Per Day Max $1,800**	**$500 Copay Per Day**	**70%** (after deductible)
In-Patient Physician Fees	No Copay	No Copay	No Copay
Emergency Room	$200 Copay (waived if admitted)	$250 Copay (waived if admitted)	$250 Copay (after deductible - waived if admitted)
RX BENEFIT - Generic	**$15 Copay**	**$20 Copay**	**$15 Copay**
- Brand Formulary①	**$150 Ded - $30 Copay**	**$200 Ded - $30 Copay**	**$250 Ded - $30 Copay**
Oral Contraceptives Covered	Yes	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	No Copay	No Copay	No Copay
Out-of-Pocket Max - Ind/Fam	$3,000 / $6,000	$3,500 / $7,000	$4,000 / $8,000
2nd Surgical Opinion	$30 Copay	$40 Copay	$40 Copay
Out-Patient Surgery	$400 Copay	$500 Copay	70% (after deductible)
Home Health Care	No Copay	No Copay	No Copay
Skilled Nursing Facility	No Copay	No Copay	No Copay (after deductible)
Ambulance	$200 Per Trip	$200 Per Trip	$200 Per Trip
Pre-Existing Conditions	Covered	Covered	Covered
Mental / Nervous Severe / Non-Severe: ②③ Doctor Fees - Annual Maximum	100% No Maximum	100% No Maximum	100% No Maximum
Hospital Fees	$450 Copay Per Day - Max $1,800	$500 Copay Per Day	70% (after deductible)
Drug / Alcohol: ③ Hospital Fees	$450 Copay Per Day-Max $1,800	$500 Copay Per Day	70% (after deductible)

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug. The amount paid does not apply to the member's brand-name deductible.

② Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizophrenic disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

③ Pre-service review is required for the following mental or nervous disorders and substance abuse services: 1) Facility-based treatment or you will be required to pay a $250 Copayment if pre-service review is not obtained; and 2) Outpatient professional services after twelve visits.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

California*Choice* Program

HEALTH NET - HMO SUMMARY BENEFITS & FEATURES

	HMO 15*^	HMO 25*^	HMO 25 Value*	HMO 30*^
MEDICAL BENEFITS				
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR. OFFICE VISITS	**$15 Copay**	**$25 Copay**	**$25 Copay**	**$30 Copay**
Lab and X-Ray	$15 Copay	$25 Copay	$25 Copay	$30 Copay
MRI, CT, and PET	100%	$50 Copay	$50 Copay	$50 Copay
HOSPITAL SERVICES	**$400 Copay - 100%**	**$450 Copay Per Day Max $1,800**	**75%**	**$450 Copay Per Day Max $1,800**
In-Patient Physician Fees	100%	100%	100%	100%
Emergency Room	$100 Copay (waived if admitted)	$150 Copay (waived if admitted)	$150 Copay (waived if admitted)	$200 Copay (waived if admitted)
RX BENEFIT - Generic	**$10 Copay**	**$15 Copay**	**$15 Copay**	**$15 Copay**
- Brand Name	**$20 Copay**	**$100 Ded - $30 Copay**	**$100 Ded - $30 Copay**	**$150 Ded - $30 Copay**
Oral Contraceptives Covered	Yes	Yes	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max - Ind/Fam	$2,000 / $4,000	$3,000 / $6,000	$3,000 / $6,000	$3,000 / $6,000
2nd Surgical Opinion	$15 Copay	$25 Copay	$25 Copay	$30 Copay
Out-Patient Surgery	$200 Copay	$400 Copay	75%	$400 Copay
Home Health Care	100%	$45 Copay	$45 Copay	$45 Copay
Skilled Nursing Facility Per Disability	$400 Copay Max 100 Days Per Year	$450 Copay Per Day Max $1,800/100 Days Per Yr	75% Max 100 Days Per Year	$450 Per Day Max $1,800/100 Days Per Yr
Ambulance	$50 Per Trip	$200 Per Trip	$200 Per Trip	$200 Per Trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental / Nervous Non-Severe: ① Doctor Fees - Annual Maximum	$30 Copay 20 Visits Per Year	$40 Copay 20 Visits Per Year	$40 Copay 20 Visits Per Year	$40 Copay 20 Visits Per Year
Hospital Fees	Not Covered	Not Covered	Not Covered	Not Covered
Drug / Alcohol:				
Hospital Fees	$400 Copay - 100% Acute Detox Only	$450 Copay Per Day-Max $1,800-Acute Detox Only	75% Acute Detox Only	$450 Copay Per Day Max $1,800-Acute Detox Only

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizophrenic disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

California*Choice* Program

HEALTH NET - HMO SUMMARY BENEFITS & FEATURES (continued)

MEDICAL BENEFITS	HMO 30 Value*	HMO 40*^	HMO 40 Value*	Elect Open Access*
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR. OFFICE VISITS	**$30 Copay**	**$40 Copay**	**$40 Copay**	**$25 Copay HMO** **$40 Copay PPO**
Lab and X-Ray	$30 Copay	$40 Copay	$40 Copay	75%
MRI, CT, and PET	$50 Copay	$50 Copay	$50 Copay	75%
HOSPITAL SERVICES	**70%**	**$500 Copay Per Day**	**60%**	**75%**
In-Patient Physician Fees	100%	100%	100%	100%
Emergency Room	$200 Copay (waived if admitted)	$250 Copay (waived if admitted)	$250 Copay (waived if admitted)	75%
RX BENEFIT - Generic	**$20 Copay**	**$20 Copay**	**$20 Copay**	**$15 Copay**
- Brand Name	**$200 Ded - $30 Copay**	**$200 Ded - $30 Copay**	**$200 Ded - $30 Copay**	**$150 Ded - $30 Copay**
Oral Contraceptives Covered	Yes	Yes	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max - Ind/Fam	$3,500 / $7,000	$3,500 / $7,000	$3,500 / $7,000	$2,500 - Individual $5,000 - Two Party $6,000 - Family
2nd Surgical Opinion	$30 Copay	$40 Copay	$40 Copay	$25 Copay
Out-Patient Surgery	70%	$500 Copay	60%	75%
Home Health Care	$45 Copay	$50 Copay	$50 Copay	$30 Copay
Skilled Nursing Facility Per Disability	70% Max 100 Days Per Year	$500 Per Day Max 100 Days Per Year	60% Max 100 Days Per Year	75% Max 100 Days Per Year
Ambulance	$200 Per Trip	$200 Per Trip	$200 Per Trip	100%
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental / Nervous Non-Severe: ① Doctor Fees - Annual Maximum	$40 Copay 20 Visits Per Year	$50 Copay 20 Visits Per Year	$50 Copay 20 Visits Per Year	$30 Copay 20 Visits Per Year
Hospital Fees	Not Covered	Not Covered	Not Covered	75% 30 Days Per Year
Drug / Alcohol:				
Hospital Fees	70% Acute Detox Only	$500 Copay Per Day Acute Detox Only	60% Acute Detox Only	75% Acute Detox Only

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizophrenic disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

KAISER PERMANENTE - HMO SUMMARY BENEFITS & FEATURES

MEDICAL BENEFITS	HMO 15^	HMO 25^	HMO 30^	HMO 40^
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR. OFFICE VISITS	**$15 Copay**	**$25 Copay**	**$30 Copay**	**$40 Copay**
Lab and X-Ray	$15 Copay	$5 Per Encounter	$10 Per Encounter	$10 Per Encounter
MRI, CT, and PET	100%	$50 Per Procedure	$50 Per Procedure	$50 Per Procedure
HOSPITAL SERVICES	**$400 Copay - 100%**	**$400 Copay Per Admission**	**$450 Copay Per Admission**	**$500 Copay Per Day**
In-Patient Physician Fees	100%	100%	100%	100%
Emergency Room	$100 Copay (waived if admitted)	$150 Copay (waived if admitted)	$200 Copay (waived if admitted)	$250 Copay (waived if admitted)
RX BENEFIT - Generic	**$10 Copay**	**$10 Copay**	**$15 Copay**	**$15 Copay**
- Brand Name	**$20 Copay**	**$25 Copay**	**$30 Copay**	**$30 Copay**
Oral Contraceptives Covered	Yes	Yes	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max - Ind/Fam	$2,000 / $4,000	$2,500 / $5,000	$3,000 / $6,000	$3,500 / $7,000
2nd Surgical Opinion	$15 Copay	$25 Copay	$30 Copay	$40 Copay
Out-Patient Surgery	$200 Copay	$300 Copay	$400 Copay	$500 Copay
Home Health Care	100%	100%	100%	100%
Skilled Nursing Facility Per Disability	$400 Copay Max 100 Days Per Year	$100 Copay Max 100 Days Per Year	$100 Copay Max 100 Days Per Year	$100 Copay Max 100 Days Per Year
Ambulance	$50 Per Trip	$100 Per Trip	$200 Per Trip	$200 Per Trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental / Nervous Non-Severe: ① Doctor Fees - Annual Maximum	$30 Copay 20 Visits Per Year	$25 Copay	$30 Copay	$40 Copay
Hospital Fees	Not Covered	$400 Copay Per Admission	$450 Copay Per Admission	$500 Copay Per Day
Drug / Alcohol:				
Hospital Fees	$400 Copay - 100% Acute Detox Only	$400 Copay Per Admission Acute Detox Only	$450 Copay Per Admission Acute Detox Only	$500 Copay Per Day Acute Detox Only

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

California*Choice* Program

SHARP HEALTH PLAN - HMO SUMMARY BENEFITS & FEATURES

	HMO 15^	HMO 25^	HMO 30^	HMO 40^
MEDICAL BENEFITS				
Deductible	No Deductible	No Deductible	No Deductible	No Deductible
DR. OFFICE VISITS	**$15 Copay**	**$25 Copay**	**$30 Copay**	**$40 Copay**
Lab and X-Ray	$15 Copay	$25 Copay	$30 Copay	$40 Copay
MRI, CT, and PET	100%	100%	$50 Copay	$50 Copay
HOSPITAL SERVICES	**$400 Copay - 100%**	**$400 Copay Per Day Max $1,200**	**$450 Copay Per Day Max $1,800**	**$500 Copay Per Day**
In-Patient Physician Fees	100%	100%	100%	100%
Emergency Room	$100 Copay (waived if admitted)	$150 Copay (waived if admitted)	$200 Copay (waived if admitted)	$250 Copay (waived if admitted)
RX BENEFIT - Generic	**$10 Copay**	**$15 Copay**	**$15 Copay**	**$20 Copay**
- Brand Name	**$20 Copay**	**$100 Ded - $30 Copay**	**$150 Ded - $30 Copay**	**$200 Ded - $30 Copay**
Oral Contraceptives Covered	Yes	Yes	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max - Ind/Fam	$2,000 / $4,000	$2,500 / $5,000	$3,000 / $6,000	$3,500 / $7,000
2nd Surgical Opinion	$15 Copay	$25 Copay	$30 Copay	$40 Copay
Out-Patient Surgery	$200 Copay	$300 Copay	$400 Copay	$500 Copay
Home Health Care	100%	$30 Copay	$45 Copay	$50 Copay
Skilled Nursing Facility Per Disability	$400 Copay Max 100 Days Per Year	$400 Per Day Max $1,200/100 Days Per Yr	$450 Per Day Max $1,800/100 Days Per Yr	$500 Per Day Max 100 Days Per Year
Ambulance	$50 Per Trip	$100 Per Trip	$200 Per Trip	$200 Per Trip
Pre-Existing Conditions	Covered	Covered	Covered	Covered
Mental / Nervous Non-Severe: ① Doctor Fees - Annual Maximum	$30 Copay 20 Visits Per Year	$40 Copay 20 Visits Per Year	$40 Copay 20 Visits Per Year	$50 Copay 20 Visits Per Year
Hospital Fees	Not Covered	Not Covered	Not Covered	Not Covered
Drug / Alcohol:				
Hospital Fees	$400 Copay - 100% Acute Detox Only	$400 Copay Per Day Max $1,200 - Acute Detox Only	$450 Copay Per Day Max $1,800-Acute Detox Only	$500 Copay Per Day Acute Detox Only

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

WESTERN HEALTH ADVANTAGE - HMO SUMMARY BENEFITS & FEATURES

MEDICAL BENEFITS	HMO 15^	HMO 25^	HMO 30^
Deductible	No Deductible	No Deductible	No Deductible
DR. OFFICE VISITS	**$15 Copay**	**$25 Copay**	**$30 Copay**
Lab and X-Ray	$15 Copay	$25 Copay	$30 Copay
MRI, CT, and PET	100%	100%	$50 Copay
HOSPITAL SERVICES	**$ 400 Copay - 100%**	**$400 Copay Per Day Max $1,200**	**$450 Copay Per Day Max $1,800**
In-Patient Physician Fees	100%	100%	100%
Emergency Room	$100 Copay (waived if admitted)	$150 Copay (waived if admitted)	$200 Copay (waived if admitted)
RX BENEFIT - Generic	**$10 Copay**	**$15 Copay**	**$15 Copay**
- Brand Name	**$20 Copay**	**$100 Ded - $30 Copay**	**$150 Ded - $30 Copay**
Oral Contraceptives Covered	Yes	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max - Ind/Fam	$2,000 / $4,000	$2,500 / $5,000	$3,000 / $6,000
2nd Surgical Opinion	$15 Copay	$25 Copay	$30 Copay
Out-Patient Surgery	$200 Copay	$300 Copay	$400 Copay
Home Health Care	100%	$30 Copay	$45 Copay
Skilled Nursing Facility Per Disability	$400 Copay Max 100 Days Per Year	$400 Per Day Max $1,200/100 Days Per Year	$450 Per Day Max $1,800/100 Days Per Year
Ambulance	$50 Per Trip	$100 Per Trip	$200 Per Trip
Pre-Existing Conditions	Covered	Covered	Covered
Mental / Nervous Non-Severe: ① Doctor Fees - Annual Maximum	$30 Copay 20 Visits Per Year	$25 Copay	$30 Copay
Hospital Fees	Not Covered	$400 Copay Per Day-Max $1,200	$450 Copay Per Day-Max $1,800
Drug / Alcohol: Hospital Fees	$400 Copay - 100% Acute Detox Only	$400 Copay Per Day - Max $1,200 Acute Detox Only	$450 Copay Per Day-Max $1,800 Acute Detox Only

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

WESTERN HEALTH ADVANTAGE - HMO SUMMARY BENEFITS & FEATURES (cont.)

MEDICAL BENEFITS	HMO 40^	HMO 40 Value
Deductible	No Deductible	$2,500 Individual / $5,000 Family
DR. OFFICE VISITS	**$40 Copay**	**$40 Copay**
Lab and X-Ray	$40 Copay	100%
MRI, CT, and PET	$50 Copay	$50 Copay
HOSPITAL SERVICES	**$ 500 Copay Per Day**	**$500 Copay Per Day** (after deductible / applies to max OOP)
In-Patient Physician Fees	100%	100%
Emergency Room	$250 Copay (waived if admitted)	$250 Copay (after ded. / waived if admitted)
RX BENEFIT - Generic	**$20 Copay**	**$20 Copay**
- Brand Name	**$200 Ded - $30 Copay**	**$250 Ded - $30 Copay**
Oral Contraceptives Covered	Yes	Yes
Maternity	Covered As Any Illness	Covered As Any Illness
Chiropractic	Not Covered	Not Covered
Out-of-Pocket Max - Ind/Fam	$3,500 / $7,000	$5,000 / $10,000
2nd Surgical Opinion	$40 Copay	$40 Copay
Out-Patient Surgery	$500 Copay	$250 Copay
Home Health Care	$50 Copay	100%
Skilled Nursing Facility Per Disability	$500 Per Day Max 100 Days Per Year	$500 Per Day Max 100 Days Per Year
Ambulance	$200 Per Trip	$50 Per Trip
Pre-Existing Conditions	Covered	Covered
Mental / Nervous Non-Severe: ① Doctor Fees - Annual Maximum	$40 Copay	$40 Copay
Hospital Fees	$500 Per Day	$500 Per Day (after deductible)
Drug / Alcohol:		
Hospital Fees	$500 Copay Per Day Acute Detox Only	$500 Copay Per Day Acute Detox Only (after deductible)

^ Copayment shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

① Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions. These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs, if the plan includes drug coverage.

The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copayments and individual and family deductibles.

"Severe Mental Illness" includes: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorders, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia and bulimia nervosa.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

California*Choice* Program

PPO - SUMMARY BENEFITS & FEATURES

MEDICAL BENEFITS	PPO 750	PPO 1000 In-Network	PPO 1000 Out-of-Network
Deductible / Family Maximum	**Plan not available for this group size.**	$1,000 per member / $3,000 per family	
Out-of-Pocket Max-Ind/Fam①		$4,500/$9,000 (Includes Ded)	$10,000 Per Member④
Lifetime Maximum		Unlimited	
DR. OFFICE VISITS		**$40 Copay**	**50%**
Annual Physical Exam		100% (ded. waived)	Not Covered
Lab And X-Ray		70%	50%
HOSPITAL SERVICES		**$1,000 Copay- 70%**	**Covered up to $650 Per Day⑤**
In-Patient Physician Fees	Note: Plan availability will be determined by the number of medically enrolled employees	70%	50%
Emergency Room		$150 (waived if admitted)-70%	$150 (waived if admitted)-70%
Out-Patient Surgery		$500 Copay - 70%	Covered up to $380 Per Day⑤
Hospital Pre-Authorization		Required or Additional $250 Copay Applies	
RX BENEFITS			
Generic Formulary		**$15 Copay**	**$15 Copay⑥**
Formulary Brand②	**Groups of 2-9:** All plans except the PPO 750.	$200 Ded - $30 Copay	$200 Ded - $30 Copay⑥
Non-Formulary Brand②		$200 Ded - $50 Copay	$200 Ded - $50 Copay⑥
Oral Contraceptives		Covered	Covered
Maternity		Covered As Any Illness	Covered As Any Illness
Ambulance		70%	50%
Physical/Occupational Therapy and Chiropractic Care		70%	Covered up to $25 per visit
		Maximum 24 Visits Per year	
Hospice	**Groups of 10+:** All plans available.	70%	50%
Skilled Nursing Facility		70%	Covered up to $150 Per Day⑤
		Max 100 Days Per Year	
Drug & Alcohol Benefits, Mental & Nervous Benefits③ (severe and non-severe)			
Outpatient		70%	100%
Inpatient		$1,000 Copay-70%	Covered up to $650 Per Day⑤

Note: Out-of-Network benefits are covered at a Negotiated Fee and members are responsible for additional amounts exceeding the Negotiated Fee rate and charges in excess of covered expenses. Plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

① The following do not apply to the out-of-pocket maximum: inpatient, outpatient and ambulatory surgical facility copays, brand name deductibles and copays for pharmacy benefits, copays for acupuncture/acupressure, copays for not obtaining pre-service review; infertility copay; and non-covered expenses. The insured remains responsible for these amounts even after the out-of-pocket maximum has been met.

② If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible.

③ Pre-service review is required for the following mental or nervous disorders and substance abuse services; 1) Facility-based treatment or you will be required to pay a $250 copayment if pre-service review is not obtained; and 2) Outpatient professional services after twelve visits.

④ Once Anthem Blue Cross payments reach $10,000 per insured, the insured pays nothing for covered expenses for the remainder of the year.

⑤ The coverage amount listed is the maximum allowed charge for non-emergency services received from a non-participating hospital or non-participating provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.

⑥ Benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

PPO - SUMMARY BENEFITS & FEATURES (cont.)

MEDICAL BENEFITS	PPO 3000 In-Network	PPO 3000 Out-of-Network	PPO 4000 In-Network	PPO 4000 Out-of-Network
Deductible / Family Maximum	$3,000 per member / $9,000 per family		$4,000 per member / $10,000 per family	
Out-of-Pocket Max-Ind/Fam①	$7,000 / $14,000 (Includes Ded)	$10,000 Per Member④	$7,000/$14,000 (Includes Ded)	$10,000 Per Member④
Lifetime Maximum	Unlimited		Unlimited	
DR. OFFICE VISITS	**$30 Copay**	**50%**	**$40 Copay**	**50%**
Annual Physical Exam	100% (ded. waived)	Not Covered	100% (ded. waived)	Not Covered
Lab And X-Ray	70%	50%	60%	50%
HOSPITAL SERVICES	**$500 Copay - 70%**	**Covered up to $650 Per Day⑤**	**$500 Copay- 60%**	**Covered up to $650 Per Day⑤**
In-Patient Physician Fees	70%	50%	60%	50%
Emergency Room	$150 (waived if admitted)-70%	$150 (waived if admitted)-70%	$150 (waived if admitted)-60%	$150 (waived if admitted)-60%
Out-Patient Surgery	$500 Copay - 70%	Covered up to $380 Per Day⑤	$500 Copay - 60%	Covered up to $380 Per Day⑤
Hospital Pre-Authorization	Required or Additional $250 Copay Applies		Required or Additional $250 Copay Applies	
RX BENEFITS				
Generic Formulary	**$15 Copay**	**$15 Copay⑥**	**$15 Copay**	**$15 Copay⑥**
Formulary Brand②	$250 Ded - $30 Copay	$250 Ded - $30 Copay⑥	$250 Ded - $30 Copay	$250 Ded - $30 Copay⑥
Non-Formulary Brand②	$250 Ded - $50 Copay	$250 Ded - $50 Copay⑥	$250 Ded - $50 Copay	$250 Ded - $50 Copay⑥
Oral Contraceptives	Covered	Covered	Covered	Covered
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Ambulance	70%	50%	60%	50%
Physical/Occupational Therapy	70%	Covered up to $25 per visit	60%	Covered up to $25 per visit
and Chiropractic Care	Maximum 24 Visits Per year		Maximum 24 Visits Per year	
Hospice	70%	50%	60%	50%
Skilled Nursing Facility	70%	Covered up to $150 Per Day⑤	60%	Covered up to $150 Per Day⑤
	Max 100 Days Per Year		Max 100 Days Per Year	
Drug & Alcohol Benefits, Mental & Nervous Benefits③ (severe and non-severe)				
Outpatient	70%	100%	60%	100%
Inpatient	$500 Copay-70%	Covered up to $650 Per Day⑤	$500 Copay-60%	Covered up to $650 Per Day⑤

Note: Out-of-Network benefits are covered at a Negotiated Fee and members are responsible for additional amounts exceeding the Negotiated Fee rate and charges in excess of covered expenses. Plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

① The following do not apply to the out-of-pocket maximum: inpatient, outpatient and ambulatory surgical facility copays, brand name deductibles and copays for pharmacy benefits, copays for acupuncture/acupressure, copays for not obtaining pre-service review; infertility copay; and non-covered expenses. The insured remains responsible for these amounts even after the out-of-pocket maximum has been met.

② If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible.

③ Pre-service review is required for the following mental or nervous disorders and substance abuse services; 1) Facility-based treatment or you will be required to pay a $250 copayment if pre-service review is not obtained; and 2) Outpatient professional services after twelve visits.

④ Once Anthem Blue Cross payments reach $10,000 per insured, the insured pays nothing for covered expenses for the remainder of the year.

⑤ The coverage amount listed is the maximum allowed charge for non-emergency services received from a non-participating hospital or non-participating provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.

⑥ Benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

CONSUMER CHOICE - SUMMARY BENEFITS & FEATURES

MEDICAL BENEFITS	Lumenos HSA 1800 In-Network	Lumenos HSA 1800 Out-of-Network	Lumenos HSA 2500 In-Network	Lumenos HSA 2500 Out-of-Network
Deductible / Family Maximum	$1,800 / $3,600④ (medical and pharmacy combined)		$2,500 / $5,000④ (medical and pharmacy combined)	
Out-of-Pocket Max-Ind/Fam①	$3,000/$5,500 (Includes Ded)	$3,000/$5,500 (Includes Ded)	$4,000/$6,000 (Includes Ded)	$4,000/$6,000 (Includes Ded)
Lifetime Maximum	Unlimited		Unlimited	
DR. OFFICE VISITS	**80%**	**50%**	**80%**	**50%**
Annual Physical Exam	100% (deductible waived)	50%	100% (deductible waived)	50%
Lab And X-Ray	80%	50%	80%	50%
HOSPITAL SERVICES	**80%**	**Covered up to $650 Per Day⑤**	**80%**	**Covered up to $650 Per Day⑤**
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room	$150 (waived if admitted) - 80%	$150 (waived if admitted) - 80%	$150 (waived if admitted) - 80%	$150 (waived if admitted) - 80%
Out-Patient Surgery	80%	Covered up to $380 Per Day⑤	80%	Covered up to $380 Per Day⑤
Hospital Pre-Authorization	Required		Required	
RX BENEFITS				
Generic Formulary	**$15 Copay** (after deductible)	**$15 Copay** ⑥ (after deductible)	**$15 Copay** (after deductible)	**$15 Copay** ⑥ (after deductible)
Formulary Brand②	$30 Copay (after deductible)	$30 Copay ⑥ (after deductible)	$30 Copay (after deductible)	$30 Copay ⑥ (after deductible)
Non-Formulary Brand②	$50 Copay (after deductible)	$50 Copay ⑥ (after deductible)	$50 Copay (after deductible)	$50 Copay ⑥ (after deductible)
Oral Contraceptives	Covered	Covered	Covered	Covered
Maternity	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness	Covered As Any Illness
Ambulance	80%	50%	80%	50%
Physical/Occupational Therapy	80%	Covered up to $25 per visit	80%	Covered up to $25 per visit
and Chiropractic Care	Maximum 24 Visits Per Year		Maximum 24 Visits Per Year	
Hospice	80%	50%	80%	50%
Skilled Nursing Facility	80%	Covered up to $150 Per Day⑤	80%	Covered up to $150 Per Day⑤
	Max 100 Days Per Year		Max 100 Days Per Year	
Drug & Alcohol Benefits, Mental & Nervous Benefits③ (server and non-severe)				
Outpatient	80%	50%	80%	50%
Inpatient	80%	Covered up to $650 Per Day⑤	80%	Covered up to $650 Per Day⑤

Note: Out-of-Network benefits are covered at a Negotiated Fee and members are responsible for additional amounts exceeding the Negotiated Fee rate and charges in excess of covered expenses. Plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

① The following do not apply to the out of pocket maximum: charges paid for acupuncture/acupressure by non-participating providers and non-covered expenses. The insured remains responsible for these amounts even after the out of pocket maximum has been met.

② If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.

③ Pre-service review is required for the following mental or nervous disorders and substance abuse services: 1) Facility-based treatment; and 2) Outpatient professional services after twelve visits.

④ Employees enrolling for single coverage must satisfy the single deductible; for employees enrolling with Dependent coverage, the family deductible must be met before any member receives benefits.

⑤ The coverage amount listed is the maximum allowed charge for non-emergency services received from a non-participating hospital or non-participating provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.

⑥ Benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

Lower your premiums and get tax deductions!

Health Savings Accounts (HSAs) offer great benefits, lower monthly premiums and the ability to save money for future medical expenses – tax free.

Lumenos HSA 1800 & 2500 – Health Savings Accounts for the way We Live!

Our Anthem Blue Cross HSAs offer you outstanding medical coverage, just like PPOs, and the added ability to contribute tax deductible amounts up to $3,050 per individual/$6,150 per family into an HSA. You earn tax-free interest and don't pay any taxes on your withdrawals when you use the money for qualified medical expenses, like doctor visit copays and prescriptions.

MEDICAL BENEFITS	Lumenos HSA 1800		Lumenos HSA 2500	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$1,800 / $3,600	$1,800 / $3,600	$2,500 / $5,000	$2,500 / $5,000
	(medical and pharmacy combined)		(medical and pharmacy combined)	
Dr. Office Visits	80%	50%	80%	50%
Hospital Services	80%	Covered up to $650 per day②	80%	Covered up to $650 per day②
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room	$150 (waived if admitted)-80%	$150 (waived if admitted)-80%	$150 (waived if admitted)-80%	$150 (waived if admitted)-80%
RX Benefit - Generic	$15 copay (After Deductible)	$15 copay③ (After Deductible)	$15 copay (After Deductible)	$15 copay ③ (After Deductible)
RX Benefit - Brand①	$30 copay (After Deductible)	$30 copay③ (After Deductible)	$30 copay (After Deductible)	$30 copay③ (After Deductible)
Out-of-Pocket Maximum-Individual/Family④	$3,000 / $5,500 (Includes Deductible)	$3,000 / $5,500 (Includes Deductible)	$4,000 / $6,000 (Includes Deductible)	$4,000 / $6,000 (Includes Deductible)
Out-Patient Surgery	80%	Covered up to $380 per day②	80%	Covered up to $380 per day②
Ambulance	80%	50%	80%	50%

The benefit grid above is for comparison only.

① If a member selects a brand-name drug when a generic-equivalent is available, even if the physician writes a "dispense as written" or "do not substitute", the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.

② The coverage amount listed is the maximum allowed charge for non-emergency services received from a Non-Participating Hospital or Non-Participating Provider. Members are responsible for all charges in excess of the covered amount. Physician Services are covered separately at 50% of Allowable Amounts.

③ Benefits apply to prescriptions filled at participating pharmacies. Please see Health Plan & Formulary Comparison Guide for non-participating pharmacy benefits.

④ The following do not apply to the out of pocket maximum: charges paid for acupuncture/acupressure by non-participating providers and non-covered expenses. The insured remains responsible for these amounts even after the out of pocket maximum has been met.

If you don't use the money in your account, you keep earning interest, year-after-year. After age 65, you can withdraw money for any reason without penalty and it's taxed as ordinary income.

Great Savings and Investment Options!

Alliance Benefit Group, American Health Value, The Bancorp Bank, First American Bank, First HSA, Health Savings Administrators and HSA Bank – offer competitive interest rates and comprehensive investment options with low minimum deposits and set-up fees and easy-to-use websites for managing the money you set aside.

Tax Deductible Contributions
Tax Free Withdrawals | *All in one program!*
Tax-Deferred Earnings

Note: We encourage you to consult with your tax advisor to determine appropriate eligibility requirements and tax advantages for participating in an HSA plan. California*Choice*® does not offer tax advice.

DENTAL SOLUTIONS A comprehensive dental program with "Choice"

Here is how it works:

Through the California*Choice* Program, you have the opportunity to offer your employees one of many great dental programs. These programs include the unique *FDH* (First Dental Health) *Access 100* Dental program ***included at no additional cost*** for all employees that enroll in medical. Or, you may offer your employees a richer prepaid benefit or a traditional EPO (Exclusive Provider Organization) or PPO plan.

FDH Access 100 Dental Program

You and your employees are eligible for the *FDH Access 100* Dental program as part of your overall benefit package, ***at no additional cost***! This value added feature offers dental discounts to every employee (and their dependents) who enroll for medical coverage through the California*Choice* Program.

Discounts are available (without prior authorization) through any of the dentists listed in the provider section of the *FDH Access 100 Dental Guide*. You do not need to select a primary care dentist. All you need to do is call for an appointment.

FDH Access 100 **participation requirements:**

- Employees and dependents (if applicable) must be enrolled for medical coverage through the California*Choice* Program.
- Employer cannot offer dental coverage through any other dental provider to any employees.

Plan 1000, 3000, 3500, 4000, 5000 Comprehensive Dental Coverage (Optional)

The California*Choice* Program also offers an optional dental package that can be included with your medical benefits program for companies seeking to offer more comprehensive benefits to their employees. This optional benefit package features a competitively priced menu that offers the choice of two Prepaid (*Plan 1000* or *Plan 3000*) dental plans, one EPO (*Plan 3500*) dental plan, or two PPO (*Plan 4000* or *Plan 5000*) dental plans.

After you have chosen to offer the full menu of comprehensive dental plans, each eligible employee may select any one of the *Prepaid*, EPO, or PPO dental plans. As with our medical plans, the employer need only contribute 50% of each participating employee's lowest cost premium.

Plan 1000 & *3000 Prepaid* members need to select their dentist from the extensive SmileSaver Dental provider network at enrollment time.

Plan 3500 EPO, Plan 4000 & *5000 PPO* members are free to visit the dentist of their choice.

Final Dental rates will be based on actual enrollment.

Voluntary Dental Coverage - Plan 3000 Only

The Prepaid *Plan 3000* can be offered as a Voluntary Plan with no minimum employee participation requirement. Enrolling members need to select their dentist from the extensive SmileSaver Dental provider network at enrollment time.

DENTAL SOLUTIONS Access and Prepaid Plans

PLAN BENEFITS	FDH ACCESS 100	PLAN 3000	PLAN 1000
	Member Pays: (Fees are subject to change)		
EXAMS & DIAGNOSTICS			
Office Exam	No Charge / Fees Apply	No Charge / Copays Apply	No Charge / Copays Apply
Initial Oral Exam	$ 38	No Charge	No Charge
Periodic Oral Exam	$ 20	No Charge	No Charge
Teeth Cleaning	$ 70	No Charge	No Charge
Bite-Wing X-Ray	$ 32 (4 films)	No Charge	No Charge
ORAL SURGERY			
Removal of Uncomplicated Single Tooth	$ 82	$ 10 Copay	No Charge
Removal of Impacted Tooth - Partially Bony	$ 271	$ 50 Copay	No Charge
Removal of Impacted Tooth - Completely Bony	$ 348	$ 65 Copay	No Charge
RESTORATIVE			
Cavities - Amalgam, 1 Surface	$ 70	$ 9 Copay	No Charge
Cavities - Amalgam, 2 Surfaces	$ 92	$ 14 Copay	No Charge
ENDODONTICS			
Single Root Canal	$ 492	$ 100 Copay	$ 40 Copay
Bi-Root Canal	$ 583	$ 135 Copay	$ 65 Copay
Molar Root Canal	$ 849	$ 185 Copay	$ 95 Copay
PERIODONTICS			
Gingivectomy - Per Tooth	$ 121	$ 30 Copay	No Charge
Periodontal Scaling & Root Planing (quadrant)	$ 93	$ 26 Copay	$ 20 Copay
CROWNS			
Porcelain - Base Metal (posterior)	$ 658	$ 225 Copay①	$ 175 Copay①
Full Cast Noble Metal	$ 670	$ 115 Copay①	$ 60 Copay①
ORTHODONTICS			
Children (maximum age 18)	$ 3,973	$ 1,600 Copay	$ 1,600 Copay
Adult	$ 3,973	$ 1,950 Copay	$ 1,950 Copay
PROSTHETICS			
Complete Upper or Lower Denture	$ 925	$ 120 Copay	$ 70 Copay
Partial Upper or Lower Denture	$ 549	$ 110 Copay	$ 50 Copay

Note: Copays listed for plans 3000 and 1000 are for services performed by general dentists. Please consult the EOC for specialist copays.

① Cost of high noble metal (gold, etc.) may be charged extra when used. Not to exceed actual laboratory cost of metal.

PREMIUMS Plan / Carrier	Dental	Orthodontia	Total Premiums					
FDH Access 100								
First Dental Health	*This benefit is included at no additional cost.*							
Plan 3000					**Dental**	**Ortho**		**Total**
SmileSaver - Single	$ 10.05	Included	Employee	$	20.10	Included	$	20.10
Additional - 1 Dependent	$ 10.05	Included	Dependents	$	10.05	Included	$	10.05
Additional - 2 + Dependents	$ 18.85	Included	Total	$	30.15	Included	$	30.15
Plan 1000								
SmileSaver - Single	$ 20.02	Included	Employee	$	40.04	Included	$	40.04
Additional - 1 Dependent	$ 13.38	Included	Dependents	$	13.38	Included	$	13.38
Additional- 2 + Dependents	$ 26.44	Included	Total	$	53.42	Included	$	53.42

DENTAL SOLUTIONS — EPO and PPO Plans

PLAN BENEFITS	EPO 3500 In-Network[1]	EPO 3500 Out-of-Network[1]	PPO 4000 In-Network	PPO 4000 Out-of-Network	PPO 5000 In-Network	PPO 5000 Out-of-Network
Annual Maximum	$ 1,000	$ 1,000	$ 1,000	$ 1,000	$ 1,500	$ 1,500
Annual Deductible	$ 50	$ 50	$ 50	$ 50	$ 50	$ 50
Preventive Care	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies
Preventive	100%	100%	100%	80%	100%	80%
Basic	80%	80%	80%	80%	80%	80%
Major (12 Month Wait)[2]	50%	50%	50%	50%	50%	50%
Endo & Periodontics	80%[2]	50%[2]	80%	50%[2]	80%	50%[2]
Restorative	80%	80%[3]	80%	80%[3]	80%	80%[3]

① Plan 3500 claims are reimbursed at the First Dental Health (FDH) contracted fees both in network and out of network. In network providers are in California only.

② For groups with 10 or more employees, the waiting period for major services will be waived for individuals who were enrolled under the employer's comparable group dental plan for 12 months or more. Credit will be given for time on the prior plan. All new hires and groups without prior comparable dental coverage are subject to the waiting period.

③ For groups of 2-4 employees, out-of-network restorative is covered at 50%, no waiting period.

NEW! DENTAL REWARDS	EPO 3500	PPO 4000	PPO 5000
Carry Over Amount	$ 250	$ 250	$ 250
PPO Bonus	$ 100	$ 100	$ 150
Benefit Threshold	$ 500	$ 500	$ 750
Maximum Carry Over Amount	$ 1,000	$ 1,000	$ 1,000

Dental RewardsSM rewards members who visit the dentist and use only a portion of their annual maximum benefit in a year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit - if they use less than half of the annual maximum, they earn $250 for next year's coverage and an additional $100 if they use any dentist in the PPO network.

Orthodontia is an optional benefit chosen for the entire group by the employer.

OPTIONAL ORTHODONTIA[6]	All Plans[4] In-Network	All Plans[4] Out-of-Network
Orthodontia (24 month wait)[5]	50%	50%
Annual Maximum	None	None
Lifetime Maximum	$ 1,000	$ 1,000

④ Orthodontia available to groups of 5 or more eligible employees.

⑤ For groups with 10 or more employees, the waiting period for orthodontia will be waived for individuals who were enrolled under the employer's comparable group dental plan for 24 months or more. Credit will be given for time on the prior plan if orthodontia was covered. All new hires and groups without prior comparable dental coverage are subject to the waiting period.

⑥ Orthodontia benefits are available to children only. Treatment must begin prior to their 19th birthday.

PREMIUMS Plan / Carrier	Dental	Orthodontia[6]	Total Premium		Dental	Ortho[6]		Total
EPO 3500								
Ameritas Group - Single	$ 29.60	Not Available	Employee	$	59.20	N/A	$	59.20
Additional - 1 Dependent	$ 26.30	Not Requested	Dependents	$	26.30	N/A	$	26.30
Additional - 2+ Dependents	$ 60.30	Not Requested	Total	$	85.50	N/A	$	85.50
PPO 4000								
Ameritas Group - Single	$ 61.00	Not Available	Employee	$	122.00	N/A	$	122.00
Additional - 1 Dependent	$ 55.30	Not Requested	Dependents	$	55.30	N/A	$	55.30
Additional - 2+ Dependents	$ 128.40	Not Requested	Total	$	177.30	N/A	$	177.30
PPO 5000								
Ameritas Group - Single	$ 68.50	Not Available	Employee	$	137.00	N/A	$	137.00
Additional - 1 Dependent	$ 61.70	Not Requested	Dependents	$	61.70	N/A	$	61.70
Additional - 2+ Dependents	$ 143.50	Not Requested	Total	$	198.70	N/A	$	198.70

Note: Final dental rates will be based on actual enrollment.

Please refer to the California*Choice* Program brochure for more detailed benefit information.

California*Choice* Program

EMPLOYEE ENROLLMENT WORKSHEET

Effective Date: **02/01/11**
Quote #: **973147**
Employer Zip Code: **92618**

PHAT PLANET MUSIC INC.
Sample Employee - Age 39
Residence Zip Code: **91604**

All Prepaid Dental benefits are covered In-Network only.

Prepaid Dental Plans	Plan 3000	Plan 1000
Exams and Diagnostics		
Annual Maximum	Unlimited	Unlimited
Annual Deductible	No Deductible	No Deductible
Initial Oral Exam	No Charge	No Charge
Periodic Oral Exam	No Charge	No Charge
Teeth Cleaning	No Charge	No Charge
Bite Wing X-Ray	No Charge	No Charge
Restorative		
Cavities - Amalgam, 1 Surface	$ 9 Copay	No Charge
Cavities - Amalgam, 2 Surfaces	$ 14 Copay	No Charge
Crowns		
Porcelain - Base Metal (Posterior)	$ 225 Copay①	$ 175 Copay①
Full Cast Noble Metal	$ 115 Copay①	$ 60 Copay①
Periodontics		
Gingivectomy - Per Tooth	$ 30 Copay	No Charge
Periodontal Scaling & Root Planing (quadrant)	$ 26 Copay	$ 20 Copay
Endodontics		
Single Root Canal	$ 100 Copay	$ 40 Copay
Bi-Root Canal	$ 135 Copay	$ 65 Copay
Molar Root Canal	$ 185 Copay	$ 95 Copay
Oral Surgery		
Removal of Uncomplicated Single Tooth	$ 10 Copay	No Charge
Removal of Impacted Tooth-Partially Bony	$ 50 Copay	No Charge
Removal of Impacted Tooth-Completely Bony	$ 65 Copay	No Charge
Orthodontics		
Children (maximum age 18)	$1,600 Copay	$1,600 Copay
Adult	$1,950 Copay	$1,950 Copay
Prosthodontics		
Complete Upper or Lower Denture	$ 120 Copay	$ 70 Copay
Partial Upper or Lower Denture	$ 110 Copay	$ 50 Copay

NOTE: Copays listed are for services performed by general dentists. Please consult the EOC for specialist copays.
① Cost of high noble metal (gold, etc.) may be charged extra when used, not to exceed actual laboratory cost of metal.

EPO/PPO Dental Plans	EPO 3500②	PPO 4000	PPO 5000
In-Network	EPO Network	PPO Network	PPO Network
Annual Maximum	$1,000	$1,000	$1,500
Annual Deductible	$ 50	$ 50	$ 50
Preventive Care	Ded. Waived	Ded. Waived	Ded. Waived
Preventive	100%	100%	100%
Basic	80%	80%	80%
Major	50%③	50%③	50%③
Endo & Periodontics	80%③	80%	80%
Restorative	80%	80%	80%
Orthodontia Adult	Not Covered	Not Covered	Not Covered
Orthodontia Children (maximum age 18)	Not Covered	Not Covered	Not Covered
Out-of-Network			
Annual Maximum	$1,000	$1,000	$1,500
Annual Deductible	$ 50	$ 50	$ 50
Preventive Care	Ded. Applies	Ded. Applies	Ded. Applies
Preventive	100%	80%	80%
Basic	80%	80%	80%
Major	50%③	50%③	50%③
Endo & Periodontics	50%③	50%③	50%③
Restorative	80%⑤	80%⑤	80%⑤
Orthodontia Adult	Not Covered	Not Covered	Not Covered
Orthodontia Children (maximum age 18)	Not Covered	Not Covered	Not Covered
Dental Rewards			
Carry Over Amount	$ 250	$ 250	$ 250
PPO Bonus	$ 100	$ 100	$ 150
Benefit Threshold	$ 500	$ 500	$ 750
Maximum Carry Over Amount	$ 1,000	$ 1,000	$ 1,000

② Plan 3500 claims are reimbursed at the First Dental Health (FDH) contracted fees both in network and out of network. In network providers are in California only.

③ 12 month waiting period applies. For groups with 10 or more employees, the waiting period will be waived for individuals who were enrolled under the employer's comparable group dental plan for 12 months or more. Credit will be given for time on the prior plan. All new hires and groups without prior comparable dental coverage are subject to the waiting period.

④ 24 month waiting period applies. For groups with 10 or more employees, the waiting period will be waived for individuals who were enrolled under the employer's comparable group dental plan for 24 months or more. Credit will be given for time on the prior plan if orthodontia was covered. All new hires and groups without prior comparable dental coverage are subject to the waiting period.

⑤ For groups of 2-4 employees, out of network restorative is covered at 50%, no waiting period.

The following premiums illustrate the cost to you ***before*** your employer has made their contribution. Subtract the amount your employer has agreed to contribute to determine the amount you will be required to pay. All family members must enroll with the same Participating Plan.

Your Employer has agreed to contribute:
_____ For Employee
_____ For Dependent

Have we correctly listed your **Age** and **Residence Zip Code** above? ❐ **Yes** ❐ **No** (If no, your quoted premium may be incorrect. Please notify your Health Plan Administrator.)

California*Choice* - Prepaid Plans	THESE ARE YOUR COSTS PER MONTH.		
SmileSaver	**Employee Only**	**Additional Cost for One Dependent**	**Additional Cost for Two + Dependents**
Plan 3000	$ 10.05	$ 10.05	$ 18.85
Plan 1000	$ 20.02	$ 13.38	$ 26.44
California*Choice* - EPO/PPO Plans			
Ameritas Group			
EPO 3500	$ 29.60	$ 26.30	$ 60.30
PPO 4000	$ 61.00	$ 55.30	$ 128.40
PPO 5000	$ 68.50	$ 61.70	$ 143.50

We assume no liability for rate or benefit discrepancies. See Evidence of Coverage for complete benefits.

OPTIONAL LIFE AND AD&D INSURANCE By Assurity Life Insurance Company

ELIGIBILITY

An employee is eligible for Life coverage if he or she is actively working the minimum number of hours per week you require an employee to be eligible for medical coverage, and appears on the employer's wage and tax report. ***All eligible employees waiving medical and/or dental coverage are required to enroll as Life Only participants.***

BENEFIT OPTIONS

Flat Amount: You may select an equal amount of insurance for each employee.

Schedule By Class: You may select a different amount for each class (up to 4 classes).

Life Insurance amounts available vary by group size. You may select a ***Flat Amount*** or ***Schedule By Class*** using any increment of $5,000 including minimum and maximum amount available to your group size. When selecting the ***Schedule By Class*** option, *the highest amount cannot be more than 2.5 times that of the lowest amount.*

Group Size	Life Amounts Available
2-10	**$10,000 - $25,000**
11-25	**$10,000 - $50,000**
26-50	**$10,000 - $75,000**

All Life Amounts are Guarantee Issue based on group size.

AD&D

An Accidental Death & Dismemberment benefit is included and is equal to the life amount. The loss must occur within 90 days of the accident.

DEPENDENT LIFE

Not Available

REDUCTION SCHEDULE

Age	Reduction of Prior to Age 70 Coverage
70-74	30%
75+	60%

LIFE BENEFITS QUOTED

Life Amount	Flat Amount of $10,000
Total Life Volume	**$20,000** for 2 Employees

PREMIUMS Carrier	Cost Per $1,000	Average Cost Per Employee	Total Premium
Assurity Life Insurance	**$0.21**	**$2.07**	**$4.13**

Rates quoted are based on group size at time of quote. Final rates will be determined by number of actual enrolled employees.

Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

Vision Care Benefits By EyeMed

Vision Discount Eyecare Program

All California*Choice* medical members and their dependents are eligible for immediate savings:

- **Save up to 40% on All Your Eyecare Needs**
- **Honored at Thousands of Locations Nationwide**
  You'll find providers conveniently located in stores like LensCrafters, Sears, Target, participating Pearle Vision Centers ①, JCPenney Optical and many others.
- **Save $5 or $10 on Eye Examinations**
  Many participating licensed independent Doctors of Optometry have agreed to discount their normal eyeglass exam fees by $5 and their normal contact lens exam fees by $10.
- **Easy to Use**
  Simply visit the participating provider closest to you and present your I.D. card which indicates your participation in the Vision Discount Eyecare Program.

Frames	**Employee Cost**
Any frame available at provider location	40% off retail price
Lenses (uncoated plastic)	
Single Vision	$ 50
Bifocal	$ 70
Trifocal	$ 105
Lens Options	
Standard-Progressive (no line bifocals)	$ 65
Polycarbonate	$ 40
Scratch Resistant Coating	$ 15
Ultraviolet Coating	$ 15
Solid or Gradient Tint	$ 15
Photochromic	20% off retail price
Anti-Reflective Coating	$ 45
Eye Examinations ②	
Spectacle	$ 5 off
Contact	$ 10 off

Contact Lenses (two ways to save)

1. Visit one of thousands of nationwide locations and save 15% off conventional contacts.
2. Replacement Contact Lenses by Mail can be ordered via the internet at www.eyemedcontacts.com or by calling (800) 508-1399 for your convenience and great prices.

The Voluntary Vision Program

All California*Choice* members and their dependents may enroll in the Voluntary Vision Program underwritten by Combined Insurance Company of America.

- **Comprehensive Vision Benefits**
  The Voluntary Vision Program offers you comprehensive coverage on eye care and eye wear. Out-of-Network coverage is also available.
- **Honored at Thousands of Locations Nationwide**
  You'll find providers conveniently located in stores like LensCrafters, Sears, Target, participating Pearle Vision Centers ①, JCPenney Optical and many others.
- **Easy to Use**
  Simply visit the participating provider closest to you and present your I.D. card which identifies you as a member. The provider will obtain authorization for services.

Plan Benefits

	In-Network	**Out-Of-Network Reimbursement**
Eye Examinations (1 per 12 months)	$10 Copay	Up to $20
Lenses		
Single Vision (1 per 12 months)	$10 Copay	Up to $20
Bifocal(1 per 12 months)	$10 Copay	Up to $30
Trifocal (1 per 12 months)	$10 Copay	Up to $40
Standard-Progressive (no line bifocals)	$75 Copay	Up to $30
Lens Options		
Polycarbonate	$ 40	Not Covered
Scratch Resistant Coating	$ 15	Not Covered
Ultraviolet Coating	$ 15	Not Covered
Solid or Gradient Tint	$ 15	Not Covered
Anti-Reflective Coating	$ 45	Not Covered
Frames ③ (1 per 12 months)		
Up to $100 retail value	100%	Up to $30
Contact Lenses ③ (1 pair per 12 months)		
In lieu of lenses and frames up to $100 retail value	$10 Copay	Up to $50
Contact Lens Fitting		
Standard	100%	Up to $40
Premium	90% of charge (less $40 allowance)	Up to $40

Monthly Cost

Employee Only	$ 9.75
Employee and Family	$ 20.75

① Some Pearle Vision Centers are franchises and do not participate. Pearle Vision, Inc. does not employ Doctors of Optometry and does not provide eye examinations in California. Pearle VisionCare, Inc. a licensed vision health care service plan provides eye examinations in California.

② Eye examinations are provided by licensed independent Doctors of Optometry. Be sure to call the Doctor of Optometry in advance to make an appointment and verify participation.

③ The applicable allowance amount may only be used once per benefit period on either eyeglasses or contacts.

Hearing Benefits By EPIC Hearing

HR Support By HRAnswerLink

Hearing Service Program

California*Choice*® is pleased to offer the EPIC Hearing Service Plan to you and your employees at no additional monthly cost.

Did you know:

- Hearing loss is the 3rd most chronic ailment in the nation
- 31.5 million Americans have some sort of hearing loss
- 24 million are not treated
- 16 million are working adults 35 – 65

Get discounts on:

- Hearing Tests
- Hearing Aids
- Hearing Aid Batteries
- Ear Protection
- Swim Plugs
- Musician Ear Plugs
- Hearing Aid cleaning supplies & accessories
- Assistive Listening Devices
- TV Ears (Amplifies & clarifies Television)
- Telephone amplification
- Altering and signaling devices

Advantages of EPIC Hearing Service Plan:

- Save up to 50% on brand name hearing aids
- All Levels of Technology and Hearing Aid Styles
- Reduced Costs on Services & Products
- National Network of local Ear Physicians and Audiologists
- Toll free telephone support
- Flexible payment plan
- No administrative forms or paperwork to fill out

Employees just call EPIC to activate their benefits and that's it!
For more information visit www.calchoice.com.

Online HR Support - 24/7!

California*Choice*® offers you 24-hour access to an online HR support center - FREE!

The HR Support Center offers you:

- Access to a document library with copies of Employee Handbooks, Company Policies, Job Descriptions, and HR Forms.
- The latest employment law news as well as details about laws that have been updated.
- Summaries of both State and Federal laws that affect employers.
- A database of questions and answers on subjects ranging from labor relations and recruitment to benefits and compensation.
- Articles written by HR Professionals that will provide you with tips, information and best practices to help you better manage your business and employees.
- A glossary of commonly used HR terms and definitions.
- A compilation of tools and information specific to Leave of Absence, Hiring, Performance Management, and Termination.
- Great pricing on HR posters, books, and training videos.
- A subscription to the monthly e-newsletter *HR Advisor* that is designed to keep you aware of the most current HR best practices and legal changes.

Getting Started:

Check out the Online HR Support center by registering at www.calchoice.com and clicking on HR Support.

OPTIONAL CHIROPRACTIC PLAN By Landmark Healthplan

Chiro*Plus* Program

Through the California*Choice* Program, you have the opportunity to offer all California*Choice* medically enrolled members (employees residing in California only) and their dependents access to chiropractic services. ***These services are available exclusively through Landmark Healthplan's network of providers.***

	PLAN 1 Chiropractic Only	PLAN 2 Chiro & Acupuncture
CHIROPRACTIC		
Office Visit	$ 15 Copay per visit	$ 15 Copay per visit
Includes: Examinations, Manipulation, Conjunctive Physiotherapy, X-Rays	***Maximum - 20 Visits Per Year***	***Maximum - 20 Visits Per Year combined between Chiropractic and Acupuncture***
ACUPUNCTURE		
Acupuncture Treatment	Not Covered	$ 15 Copay per visit
Herbal Therapies ①	Not Covered	$ 5 Copay per bottle (Max $500 per year)
And more...	In addition to the 20 office visits for $15, each member will have additional discounts available through Landmark Healthplan's network of providers. The additional discounts are listed below, but are not limited to:	
Chiropractic Discounts: Office Visits, Examinations, Adjustments, Diagnostic Procedures & X-Rays	*Minimum 25% Discount for professional services*	*Minimum 25% Discount for professional services*
Acupuncture Discounts: Office Visits, Examinations, Diagnostic Procedures, All Acupuncture Procedures (including electro-acupuncture, moxibustion, acupressure and cupping)	*Not Covered*	*Minimum 20% Discount for professional services*
WellCall: Wellness Referral and Counseling Services	***Health and Wellness Referral and Counseling Services*** WellCall provides resources or information to meet virtually any need for preventive health & wellness assistance, including: weight management; fitness & exercise; smoking cessation; pre & post natal care; parenting; and health self-management. Log on to www.wellcall.com or call 888-493-5522	

① Herbal Therapies are for oral ingestion or external application of naturally occurring botanical, animal, or mineral substances, to support normal structure and function of the human body according to the principles of traditional Oriental medicine.

PREMIUMS

This program requires the employer to contribute 100% with all medically enrolled employees participating.

PREMIUMS	Monthly Cost per Employee ②	Number of Employees	Total Cost
PLAN 1			
Landmark Healthcare	$2.95	2	$5.90
PLAN 2			
Landmark Healthcare	$4.92	2	$9.84

② Rates include coverage for dependents and coverage is available to employees residing in California only.

Note: Employees who select and fund an HSA plan are not eligible for chiropractic benefits.
Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

OPTIONAL PREMIUM ONLY PLAN (P.O.P.) Administered by CONEXIS

WHAT IS A PREMIUM ONLY PLAN?

A Section 125 Premium Only Plan allows your employees to pay their share of insurance premiums (health, dental, group life) on a ***pre-tax*** basis. Many larger companies routinely offer the tax savings of a Premium Only Plan to their employees. Through our administrator **CONEXIS**, those same tax savings are now available to you and your employees.

PREMIUM ONLY PLAN ADVANTAGES

- A Premium Only Plan allows your employees to pay their share of health care premiums with ***pre-tax*** dollars, allowing your employees to take home more money.
- When your ***taxable payroll decreases***, you save money by reducing FICA and Workers' Compensation expenses.
- Because a Premium Only Plan will allow ***employees to stretch their income***, it becomes easier for them to assume a larger share of the premium or "buy-up" to the benefit design of their choice.
- A Premium Only Plan provides a significant tax savings for both the employer and employee. It increases your employees' paychecks and ***lowers your taxes***.

PREMIUM ONLY PLAN SAVINGS ILLUSTRATION

This illustration shows the potential savings to you and your employees with a **CONEXIS** Section 125 Premium Only Plan: ①

If the employer contributes....	Calculated Annual Employee Contribution	**Annual Employer Savings**	Collective Annual Employee Tax Savings
50% of employee medical premium & 0% dep prem	$ 7,156	$ 716	$ 1,789
50% of employee medical premium & 25% dep prem	$ 6,204	$ 620	$ 1,551
50% of employee medical premium & 50% dep prem	$ 5,252	$ 525	$ 1,313
75% of employee medical premium & 0% dep prem	$ 5,483	$ 548	$ 1,371
75% of employee medical premium & 25% dep prem	$ 4,531	$ 453	$ 1,133
75% of employee medical premium & 50% dep prem	$ 3,578	$ 358	$ 895
100% of employee medical premium & 0% dep prem	$ 3,810	$ 381	$ 952
100% of employee medical premium & 25% dep prem	$ 2,857	$ 286	$ 714
100% of employee medical premium & 50% dep prem	$ 1,905	$ 190	$ 476

① The examples above assume that:
A) all premiums are calculated by selecting the Health Plan which produces the best employee rate from benefit Plan 40 Value,
B) each employee has a combined tax bracket of 25% (7.65% FICA, 4% State income, 13.35% Federal), and
C) your workers' compensation premiums are 2.35% of your annual payroll cost.

PREMIUM ONLY PLAN FEES

Setup, Plan Documentation and Discrimination Testing: $100

What you can expect with California*Choice*.®

Thank you for taking the time to review the CaliforniaChoice® quote. We've identified a couple of expectations you can look forward to if you decide that our program is right for you.

Coverage Effective Date

The coverage effective date is indicated on the approval letter. If the effective date is different than what was requested, it may have been delayed by information missing from the submission. Please call us if you have any questions.

The Enrollment Process

Employees enroll in medical by selecting the coverage they want on their employee enrollment application.

If optional benefits like dental, vision, chiropractic or life coverage are offered, employees can also make this selection on the application.

Please note: Employees are not eligible to enroll in optional benefits not included in the group's coverage.

Payment Processing

The monthly statement will identify the group's account activity and premium due. The payment is due by the 20th of each month preceding the month of coverage.

Please note: The processing cycle is implemented at the time of approval and in some cases groups may receive an invoice before they receive their account confirmation.

Membership ID Cards

Temporary ID cards will be sent to employees in their California*Choice*® Welcome Kit after they select their benefits. Employees can use the temporary cards until permanent ID cards are issued from the health plan they selected.

Rx-Prescriptions

If prescriptions services are needed before permanent ID cards arrive, please have employees save their receipts. They'll need their receipts to request reimbursement from their health plan.

Tip: Before purchasing prescriptions, employees should make sure to check that their health plan covers the prescription they need and that they're eligible for reimbursement.

California*Choice*®
Your Health. Your Choice.®

SUMMARY OF UNDERWRITING & ENROLLMENT GUIDELINES

MAJOR MEDICAL BENEFITS

UNDERWRITING GUIDELINES

Participation Requirements

- **2 Employees:** 100% of all employees
- **3-50 Employees:** 70% of employees, with a minimum of 2 employees enrolling in California*Choice* (***Please refer to the California*Choice* Employer brochure for complete details***).
- Waiting period minimum is 30 days; maximum is 365 days

Minimum Employer Contribution

- The employer must contribute at least 50% of the best employee premium available to each employee
- No employer contribution is required for dependent coverage.

Miscellaneous Underwriting Requirements

- Husband and wife both working full time for the same employer can enroll either together or separately
- 1099 employees are not eligible
- PPO rates for employees age 65+ in groups of 2-19 are quoted assuming the employee has Medicare parts A & B
- Quoted rates for groups with a census of 4 or less eligible employees include a risk adjustment factor (RAF) of 1.10
- Standard new business rates are quoted for groups with a census of 5 or more eligible employees, but subject to a risk adjustment factor (RAF) during underwriting. See RAF Guidelines
- Groups with a final employee medical enrollment count of 15 or more ***may*** qualify to receive a RAF of .90 during the underwriting process, see RAF Guidelines
- MHP eligibility will be confirmed during underwriting

SUBMISSION REQUIREMENTS

- **Contact your sales representative for the submission deadline of the requested effective date**
- Effective date must be the first of the month
- DE-6 is required upon submission
- Premium check required upon submission
- Make check payable to C.C.B.A. (California*Choice* Benefit Administors)

MINIMUM DEPOSIT PREMIUM REQUIRED AT SUBMISSION **$ 577.81** Includes a $20.00 Monthly Billing Fee①

(The Premium Balance will be required prior to issue.)

The minimum deposit premium above is the total of the best rate available to each employee for Benefit Plan HMO 40 Value.

The dependent premium is *not* included in the Minimum Deposit Premium amount and will be an additional cost.

① **The Billing fee is determined by number of enrolled participants and varies by group size: 1-8 Employees=$20; 9-20 Employees=$25; 21+Employees=$30**

DENTAL BENEFITS

UNDERWRITING GUIDELINES

Participation Requirements

- Contributory Plans
  - Minimum employee participation must be at least 70%
  - Minimum dependent participation is 0%
- Non-Contributory Plans
  - Minimum participation is 100% of eligible employees with at least 70% enrolling regardless of other coverage

Minimum Employer Contribution

- The employer must contribute at least 50% of the best employee premium available to each employee
- No employer contribution is required for dependent coverage

Miscellaneous Underwriting Requirements

- Employee may choose optional ***Dental*** coverage without enrolling for medical insurance
- Final Dental rates will be based on actual enrollment.

SUBMISSION REQUIREMENTS

Group Size

- 10+ Must submit the prior carrier booklet and billing to receive credit for time on the prior plan.
- **The Dental premium is not included in the Minimum Deposit Premium amount and will be an additional cost. The balance, as calculated by California*Choice* Benefit Administrators, is due prior to approval.**

LIFE BENEFITS

ENROLLMENT REQUIREMENTS

- Minimum Employer Contribution for Employee - 100%
- Minimum Participation Requirement for Employee - 100%
- **The Life premium is not included in the Minimum Deposit Premium amount and will be an additional cost. The balance, as calculated by California*Choice* Benefit Administrators®, is due prior to approval.**

Please refer to the California*Choice* Program brochure for a detailed description of Plan Benefits and Underwriting Guidelines.

Employee and Dependent Rates

Monthly premiums illustrated are rounded to the nearest dollar.

	SHAW, D M39/SP/0 (91604)		D'ANDREA, M M42/NO DEPS (92618)	
Anthem Blue Cross*	Employee	Additional for Deps.	Employee	Additional for Deps.
HMO 15*	$ 646	$ 781	$ 850	*This employee did not request dependent coverage*
HMO 25*	$ 466	$ 564	$ 611	
HMO 25-V*	$ 354	$ 427	$ 475	
HMO 30*	$ 368	$ 445	$ 498	
HMO 40*	$ 328	$ 397	$ 444	
HMO 40-V*	$ 261	$ 315	$ 350	
PPO 1000	$ 620	$ 902	$ 782	
PPO 3000	$ 407	$ 592	$ 531	
PPO 4000	$ 351	$ 511	$ 458	
HSA 1800	$ 516	$ 747	$ 658	
HSA 2500	$ 421	$ 608	$ 536	
Anthem Blue Cross Select*				
HMO 15*	$ 560	$ 678	$ 714	*This employee did not request dependent coverage*
HMO 25*	$ 406	$ 491	$ 518	
HMO 25-V*	$ 317	$ 383	**$ 405**	
HMO 30*	$ 335	$ 405	$ 426	
HMO 40*	$ 298	$ 360	$ 380	
HMO 40-V*	$ 246	$ 297	**$ 314**	
Health Net*				
HMO 15*	$ 516	$ 672	$ 766	*This employee did not request dependent coverage*
HMO 25*	$ 352	$ 458	$ 564	
HMO 25-V*	$ 338	$ 440	$ 530	
HMO 30*	$ 346	$ 450	$ 524	
HMO 30-V*	$ 310	$ 404	$ 467	
HMO 40*	$ 319	$ 416	$ 428	
HMO 40-V*	$ 277	$ 361	$ 380	
EOA*	$ 387	$ 504	$ 552	
Salud	$ 211	$ 275	$ 265	
Health Net Silver*				
HMO 15*	**$ 454**	$ 592	$ 682	*This employee did not request dependent coverage*
HMO 25*	**$ 310**	$ 403	$ 502	
HMO 25-V*	**$ 297**	$ 387	$ 471	
HMO 30*	$ 304	$ 396	$ 466	
HMO 30-V*	**$ 273**	$ 355	**$ 415**	
HMO 40*	**$ 281**	$ 366	$ 381	
HMO 40-V*	**$ 244**	$ 317	$ 338	
EOA*	$ 352	$ 459	$ 513	

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

Not all health plans are available in all areas.

Note: PPO Plan availability will be determined by the number of medically enrolled employees. Groups of 2-9 = All plans except the PPO 750. Groups of 10+ = All plans available. Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

Employee and Dependent Rates

Monthly premiums illustrated are rounded to the nearest dollar.

	SHAW, D M39/SP/0 (91604)		D'ANDREA, M M42/NO DEPS (92618)	
Kaiser Permanente	Employee	Additional for Deps.	Employee	Additional for Deps.
HMO 15	$ 466	$ 801	**$ 542**	
HMO 25	$ 316	$ 542	**$ 367**	
HMO 30	**$ 303**	$ 520	**$ 352**	
HMO 40	$ 287	$ 492	**$ 333**	

Not all health plans are available in all areas.

California*Choice* Program

Rate Summary by Health Plan

Anthem Blue Cross*	HMO 15*	HMO 25*	HMO 25-Value*	HMO 30*	HMO 40*	HMO 40-Value*
Total Employee Premium	$ 1496	$ 1077	$ 828	$ 867	$ 772	$ 611
Total Dependent Premium	$ 781	$ 564	$ 427	$ 445	$ 397	$ 315
Totals	**$ 2277**	**$ 1640**	**$ 1256**	**$ 1312**	**$ 1169**	**$ 926**
Anthem Blue Cross Averages by Plan (for illustration purposes only)						
Employee	$ 748	$ 538	$ 414	$ 433	$ 386	$ 306
Additional for Spouse	$ 931	$ 669	$ 513	$ 537	$ 479	$ 379
Additional for Children	None Quoted					
Additional for Family	None Quoted					

Anthem Blue Cross Select*	HMO 15*	HMO 25*	HMO 25-Value*	HMO 30*	HMO 40*	HMO 40-Value*
Total Employee Premium	$ 1274	$ 925	$ 722	$ 761	$ 678	$ 560
Total Dependent Premium	$ 678	$ 491	$ 383	$ 405	$ 360	$ 297
Totals	**$ 1952**	**$ 1416**	**$ 1106**	**$ 1165**	**$ 1038**	**$ 857**
Anthem Blue Cross Select Averages by Plan (for illustration purposes only)						
Employee	$ 637	$ 462	$ 361	$ 380	$ 339	$ 280
Additional for Spouse	$ 792	$ 575	$ 447	$ 471	$ 420	$ 347
Additional for Children	None Quoted					
Additional for Family	None Quoted					

Anthem Blue Cross - PPO	PPO 1000	PPO 3000	PPO 4000	HSA 1800	HSA 2500	
Total Employee Premium	$ 1401	$ 939	$ 810	$ 1174	$ 956	
Total Dependent Premium	$ 902	$ 592	$ 511	$ 747	$ 608	
Totals	**$ 2303**	**$ 1531**	**$ 1321**	**$ 1921**	**$ 1565**	
Anthem Blue Cross - PPO Averages by Plan (for illustration purposes only)						
Employee	$ 701	$ 469	$ 405	$ 587	$ 478	
Additional for Spouse	$ 860	$ 574	$ 495	$ 716	$ 584	
Additional for Children	None Quoted					
Additional for Family	None Quoted					

Health Net*	HMO 15*	HMO 25*	HMO 25-Value*	HMO 30*	HMO 30-Value*	HMO 40*
Total Employee Premium	$ 1282	$ 916	$ 867	$ 869	$ 777	$ 747
Total Dependent Premium	$ 672	$ 458	$ 440	$ 450	$ 404	$ 416
Totals	**$ 1955**	**$ 1375**	**$ 1307**	**$ 1320**	**$ 1181**	**$ 1163**
Health Net Averages by Plan (for illustration purposes only)						
Employee	$ 641	$ 458	$ 434	$ 435	$ 388	$ 374
Additional for Spouse	$ 825	$ 589	$ 558	$ 559	$ 500	$ 481
Additional for Children	None Quoted					
Additional for Family	None Quoted					

Health Net (continued)*	HMO 40-Value*	EOA*	Salud	
Total Employee Premium	$ 657	$ 939	$ 476	
Total Dependent Premium	$ 361	$ 504	$ 275	
Totals	**$ 1018**	**$ 1443**	**$ 751**	
Health Net Averages by Plan (for illustration purposes only)				
Employee	$ 328	$ 469	$ 238	
Additional for Spouse	$ 423	$ 604	$ 307	
Additional for Children	None Quoted			
Additional for Family	None Quoted			

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

Note: PPO Plan availability will be determined by the number of medically enrolled employees. Groups of 2-9 = All plans except the PPO 750. Groups of 10+ = All plans available. Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

Rate Summary by Health Plan

Health Net Silver*	HMO 15*	HMO 25*	HMO 25-Value*	HMO 30*	HMO 30-Value*	HMO 40*
Total Employee Premium	$ 1136	$ 812	$ 769	$ 770	$ 688	$ 662
Total Dependent Premium	$ 592	$ 403	$ 387	$ 396	$ 355	$ 366
Totals	**$ 1728**	**$ 1215**	**$ 1156**	**$ 1167**	**$ 1044**	**$ 1028**
Health Net Silver Averages by Plan (for illustration purposes only)						
Employee	$ 568	$ 406	$ 384	$ 385	$ 344	$ 331
Additional for Spouse	$ 731	$ 522	$ 494	$ 495	$ 443	$ 426
Additional for Children	None Quoted					
Additional for Family	None Quoted					

Health Net Silver (cont.)*	HMO 40-Value*	EOA*
Total Employee Premium	$ 582	$ 865
Total Dependent Premium	$ 317	$ 459
Totals	**$ 899**	**$ 1324**
Health Net Silver Averages by Plan (for illustration purposes only)		
Employee	$ 291	$ 433
Additional for Spouse	$ 374	$ 557
Additional for Children	None Quoted	
Additional for Family	None Quoted	

Kaiser Permanente	HMO 15	HMO 25	HMO 30	HMO 40
Total Employee Premium	$ 1008	$ 683	$ 655	$ 620
Total Dependent Premium	$ 801	$ 542	$ 520	$ 492
Totals	**$ 1809**	**$ 1225**	**$ 1175**	**$ 1112**
Kaiser Permanente Averages by Plan (for illustration purposes only)				
Employee	$ 504	$ 341	$ 327	$ 310
Additional for Spouse	$ 753	$ 510	$ 489	$ 463
Additional for Children	None Quoted			
Additional for Family	None Quoted			

* Anthem Blue Cross and Health Net offer the option of an additional provider network. Those additional options are noted as: Anthem Blue Cross Select HMO and Health Net Silver (not available in all counties in California). Prior to enrollment, the employer may elect to offer the standard network **OR** these provider networks to their employees.

Note: PPO Plan availability will be determined by the number of medically enrolled employees. Groups of 2-9 = All plans except the PPO 750. Groups of 10+ = All plans available. Please refer to the California*Choice* Program brochure for more detailed plan benefit information.

RAF Guidelines

Standard new business rates may be adjusted by a Risk Adjustment Factor (RAF) based on final employee medical enrollment count determined during the underwriting process.

- Groups with 2-4 eligible employees are always quoted using standard new business rates with a RAF of 1.10.
- Groups with 5-50 eligible employees are quoted using standard new business rates. Rates for these groups are subject to a RAF based upon final employee medical enrollment count determined during the underwriting process.

The following table defines how the final RAF is applied during **Underwriting**:

Total California*Choice* Employee Medical Enrollment Count*	Final RAF applied during underwriting
2-4	1.10
5-14	1.00
15-50	.90[1] or 1.00
*COBRA medical subscribers are not included in this count.	

[1] In order to qualify for a .90 RAF the group must submit a copy of their current renewal RAF Statement from their current carrier showing a renewal RAF of 1.05 or less. The statement must be within 3 effective dates of their California*Choice* coverage requested effective date determined by underwriting. Kaiser Permanente wrap groups are among those that qualify.

Quote Disclaimer

We have endeavored to provide you with an accurate proposal based on the information given to us. Although we believe the rate and benefit information to be correct, please keep in mind that final rates and benefits are based upon actual enrollment and underwriting. Approval must be communicated by California*Choice*® Benefit Administrators. We assume no liability for rate differences and ask that you advise your client not to cancel their prior coverage until final rating information and underwriting approval has been received from California*Choice*® Benefit Administrators. This proposal contains a summary of plan benefits. For complete benefit details refer to the group service agreement or benefit guide.

If your census contains employees age 65+ the following information applies. Final rates for employees age 65+ are subject to change if the total employee count changes from the original quote census:

- Rates for employees age 65+ will be determined by total employee count and employee Medicare coverage.
- Quoted rates for employees age 65+ are determined by the information submitted at time of quote. If submitted information indicates total group size of 2-19, rates quoted are for Medicare Primary coverage. If submitted information indicates total group size of 20+, rates quoted are for Medicare Secondary coverage.

DISCLOSURE ADVISEMENT & NOTIFICATIONS
Under California law all qualifying small employer groups have the following rights when considering health insurance products:

All carriers are obliged to sell any small group employer any plan design offered to any other small group. You may request the actual rates that would be charged for any given small group plan design offered by a carrier represented by your broker.

Your broker will procure for you rate and benefit information for any small group plan design offered by a carrier represented by your broker. You may request a Summary Brochure for each carrier represented by your broker.

The summary of benefits listed in this quote have been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws and subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

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CHOICE Administrators® payrollservices Powered by Ovation Payroll

Integrate Payroll Services with Your California*Choice* Benefits!

CHOICE Administrators Payroll Services simplifies your benefits program by integrating payroll services directly with your California*Choice* health benefits. This means your payroll team can communicate with your California*Choice* team, ensuring the accuracy of your account!

For example, remove an employee from your payroll and California*Choice* is automatically notified -we'll contact you immediately to confirm the change.

PHAT PLANET MUSIC INC.

Approximate Savings for your 2 employees:

Payroll Services would cost you about **$94.20**

By combining Payroll Services with California*Choice* Health Benefits your cost will only be **$75.36***

You could save $18.84 per month!

* *This quoted monthly rate was calculated from the census you provided for a bi-weekly payroll. An Ovation Payroll consultant will be contacting you regarding this quote. For additional information please login to www.calchoice.com and select "Payroll Service Center" or call 866-644-6670.*
Rates are subject to change based on final payroll requirements.

CHOICE Administrators Payroll Services Include:

- **Direct Deposit**
  A secure, convenient, and cost effective alternative to paper checks.
- **Laser Check Signing**
  Save time and wrist pain by having us laser sign your payroll checks.
- **Check Insertion - Direct Deposit Confirmation**
  We'll insert the documents into envelopes for you ensuring complete confidentiality.
- **Free Employee Payroll Portal (Intranet)**
  Free Intranet provides employees with a secure platform to view and print pay stubs and W-2's, update their information.
- **Automatic Adds & Deletes**
  When you add or delete an employee from your payroll, California*Choice* is automatically notified.
- **Customized Payroll Reporting**
  You'll receive a Payroll Summary, Payroll Register, Payroll Tax Report and Employee Pay Stub with every payroll - and you can select a variety of standard payroll reports or create custom reports exactly the way you want.
- **Service Guarantee**: Ovation Payroll assumes full responsibility for the accurate and timely remittance and filing of payroll taxes on your behalf - and a dedicated payroll specialist will be assigned to you.