



## **Member Benefits Program**

### **Ames Grenz Insurance Services, Inc.**

*Robert Ford*  
*3435 American River Drive, Suite C*  
*Sacramento, CA 95864*  
*Phone: (916) 486-2900*  
*rford@amesgrenz.com*

*Kirstin Corrigan*  
*kcorrigan@amesgrenz.com*  
*License No. 0787081*

*Administered by American River Benefit Administrator*

## Benefit Sheet

Benefit	Kaiser Platinum 90 HMO 0/10 + Child Dental Alt (Broad Network)		Kaiser Platinum 90 HMO 0/20 + Child Dental (Broad Network)	
	In Net	Out Net	In Net	Out Net
Individual Ded	\$0		\$0	
Family Ded	\$0		\$0	
Individual OOP Max	\$3,000		\$4,500	
Family OOP Max	\$6,000		\$9,000	
Co-insurance	0%		0%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	\$10/\$20		\$20/\$30	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	\$10		\$20	
Chiropractic Care	\$15; 20 visits/yr		Not covered	
Inpatient Hospital	\$500/admit		\$250/day up to 5 days	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	\$500/admit		\$250/day up to 5 days	
Mental Health IP	\$500/admit		\$250/day up to 5 days	
Substance Abuse IP	\$500/admit		\$250/day up to 5 days	
Outpatient Facility	\$300		\$125	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	\$20/\$40		\$20/\$30	
Advanced Radiology	\$150		\$100	
Mental Health OP	\$10		\$20	
Substance Abuse OP	\$10		\$20	
Emergency Room	\$200 (waived if admitted)		\$150 (waived if admitted)	
Ambulance	\$150		\$150	
Urgent Care	\$10		\$20	
Rx Generic	\$5		\$5	
Rx Preferred	\$15		\$20	
Rx Non-Preferred	\$15		\$20	
Rx Specialty	10%; \$250 max/script		10%; \$250 max/script	
Rx Mail Order	2x retail (100 day supply)		2x retail (100 day supply)	
Home Health Care	No charge; 100 visits/yr		\$20; 100 visits/yr	
Skilled Nursing	\$250/admit; 100 days/yr		\$150/day up to 5 days; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	10% (base and supplemental)		10% (base and supplemental)	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

Formerly Platinum 0/15

## Benefit Sheet

Kaiser			Kaiser	
Gold 80 HMO 0/30 + Child Dental Alt (Broad Network)			Gold 80 HMO 250/35 + Child Dental (Broad Network)	
Benefit	In Net	Out Net	In Net	Out Net
Individual Ded	\$0		\$250	
Family Ded	\$0		\$500 (embedded)	
Individual OOP Max	\$7,000		\$7,800 (incl ded)	
Family OOP Max	\$14,000		\$15,600 (incl ded)	
Co-insurance	0%		0%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	\$30/\$35		\$35/\$55 ded waived	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	\$30		\$35 ded waived	
Chiropractic Care	\$15; 20 visits/yr		Not covered	
Inpatient Hospital	\$600/day up to 5 days		\$600/day after ded up to 5 days	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	\$600/day up to 5 days		\$600/day after ded up to 5 days	
Mental Health IP	\$600/day up to 5 days		\$600/day after ded up to 5 days	
Substance Abuse IP	\$600/day up to 5 days		\$600/day after ded up to 5 days	
Outpatient Facility	\$320		\$335 after ded	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	\$30/\$40		\$35/\$55 ded waived	
Advanced Radiology	\$250		\$250 after ded	
Mental Health OP	\$30		\$35 ded waived	
Substance Abuse OP	\$30		\$35 ded waived	
Emergency Room	\$250 (waived if admitted)		\$250 (waived if admitted) after ded	
Ambulance	\$250		\$250 after ded	
Urgent Care	\$30		\$35 ded waived	
Rx Generic	\$15		\$15 ded waived	
Rx Preferred	\$40		\$40 ded waived	
Rx Non-Preferred	\$40		\$40 ded waived	
Rx Specialty	20%; \$250 max/script		20% ded waived; \$250 max/script	
Rx Mail Order	2x retail (100 day supply)		2x retail (100 day supply)	
Home Health Care	No charge; 100 visits/yr		\$30 ded waived; 100 visits/yr	
Skilled Nursing	\$300/day up to 5 days; 100 days/yr		\$300/day after ded up to 5 days; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	20% (base and supplemental)		20% ded waived/20% after ded (base/supplemental)	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

**Formerly Gold 250/25  
Replaced Gold 500/30**

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## Benefit Sheet

<b>NEW Kaiser</b>		<b>Kaiser</b>		
Gold 80 HMO 1000/40 + Child Dental Alt (Broad Network)		Gold 80 HRA HMO 2250/35 + Child Dental (Broad Network)		
Benefit	In Net	Out Net	In Net	Out Net
<b>Individual Ded</b>	\$1,000		\$2,250	
<b>Family Ded</b>	\$2,000 (embedded)		\$4,500 (embedded)	
<b>Individual OOP Max</b>	\$7,800 (incl ded)		\$7,800 (incl ded)	
<b>Family OOP Max</b>	\$15,600 (incl ded)		\$15,600 (incl ded)	
<b>Co-insurance</b>	0%		25%	
<b>Lifetime Max</b>	Unlimited		Unlimited	
<b>PC/Specialist</b>	\$40/\$60 ded waived		\$35/\$50 ded waived	
<b>Adult Preventive Care</b>	No charge		No charge	
<b>Child Preventive Care</b>	No charge		No charge	
<b>Pre/Postnatal Care</b>	No charge		No charge	
<b>Physical Therapy</b>	\$40 ded waived		\$35 after ded	
<b>Chiropractic Care</b>	\$15 ded waived; 20 visits/yr		Not covered	
<b>Inpatient Hospital</b>	\$600/day after ded up to 5 days		25% after ded	
<b>Inpatient Surgery</b>	N/A		N/A	
<b>Maternity Delivery/IP</b>	\$600/day after ded up to 5 days		25% after ded	
<b>Mental Health IP</b>	\$600/day after ded up to 5 days		25% after ded	
<b>Substance Abuse IP</b>	\$600/day after ded up to 5 days		25% after ded	
<b>Outpatient Facility</b>	\$350 ded waived		25% after ded	
<b>Outpatient Surgery</b>	N/A		N/A	
<b>Lab/X-Ray</b>	\$30/\$60 ded waived		25% after ded	
<b>Advanced Radiology</b>	\$350 after ded		25% after ded	
<b>Mental Health OP</b>	\$40 ded waived		\$35 ded waived	
<b>Substance Abuse OP</b>	\$40 ded waived		\$35 ded waived	
<b>Emergency Room</b>	\$350 (waived if admitted) ded waived		25% after ded	
<b>Ambulance</b>	\$350 ded waived		25% after ded	
<b>Urgent Care</b>	\$40 ded waived		\$35 ded waived	
<b>Rx Generic</b>	\$20 ded waived		\$15 ded waived	
<b>Rx Preferred</b>	\$50 after \$250		\$30 after \$100	
<b>Rx Non-Preferred</b>	\$50 after \$250		\$30 after \$100	
<b>Rx Specialty</b>	20% after \$250; \$250 max/script		20% after \$100; \$250 max/script	
<b>Rx Mail Order</b>	2x retail (100 day supply)		2x retail (100 day supply)	
<b>Home Health Care</b>	No charge; 100 visits/yr		No charge; 100 visits/yr	
<b>Skilled Nursing</b>	\$300/day after ded up to 5 days; 100 days/yr		25% after ded; 100 days/yr	
<b>Infertility Treatment</b>	Not covered		Not covered	
<b>DME</b>	20% ded waived/20% after ded (base/supplemental)		50% ded waived/50% after ded (base/supplemental)	
<b>Hospice Services</b>	No charge		No charge	
<b>Pediatric Vision</b>	No charge; 1 pair/yr		No charge; 1 pair/yr	
<b>Pediatric Dental</b>	Bundled w/copay plan		Bundled w/copay plan	

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## Benefit Sheet

Kaiser			Kaiser	
Silver 70 HMO 1650/55 + Child Dental Alt (Broad Network)			Silver 70 HMO 2100/55 + Child Dental Alt (Broad Network)	
Benefit	In Net	Out Net	In Net	Out Net
<b>Individual Ded</b>	\$1,650		\$2,100	
<b>Family Ded</b>	\$3,300 (embedded)		\$4,200 (embedded)	
<b>Individual OOP Max</b>	\$8,200 (incl ded)		\$8,200 (incl ded)	
<b>Family OOP Max</b>	\$16,400 (incl ded)		\$16,400 (incl ded)	
<b>Co-insurance</b>	40%		45%	
<b>Lifetime Max</b>	Unlimited		Unlimited	
<b>PC/Specialist</b>	\$55/\$80 ded waived		\$55/\$80 ded waived	
<b>Adult Preventive Care</b>	No charge		No charge	
<b>Child Preventive Care</b>	No charge		No charge	
<b>Pre/Postnatal Care</b>	No charge		No charge	
<b>Physical Therapy</b>	\$65 ded waived		\$65 ded waived	
<b>Chiropractic Care</b>	\$15 ded waived; 20 visits/yr		\$15 ded waived; 20 visits/yr	
<b>Inpatient Hospital</b>	40% after ded		45% after ded	
<b>Inpatient Surgery</b>	N/A		N/A	
<b>Maternity Delivery/IP</b>	40% after ded		45% after ded	
<b>Mental Health IP</b>	40% after ded		45% after ded	
<b>Substance Abuse IP</b>	40% after ded		45% after ded	
<b>Outpatient Facility</b>	40% after ded		45% after ded	
<b>Outpatient Surgery</b>	N/A		N/A	
<b>Lab/X-Ray</b>	\$30/\$75 ded waived		\$30/\$75 ded waived	
<b>Advanced Radiology</b>	\$350 after ded		\$350 after ded	
<b>Mental Health OP</b>	\$55 ded waived		\$55 ded waived	
<b>Substance Abuse OP</b>	\$55 ded waived		\$55 ded waived	
<b>Emergency Room</b>	40% after ded		45% after ded	
<b>Ambulance</b>	40% after ded		45% after ded	
<b>Urgent Care</b>	\$55 ded waived		\$55 ded waived	
<b>Rx Generic</b>	\$20 ded waived		\$20 ded waived	
<b>Rx Preferred</b>	\$75 after \$350		\$75 after \$500	
<b>Rx Non-Preferred</b>	\$75 after \$350		\$75 after \$500	
<b>Rx Specialty</b>	20% after \$350; \$250 max/script		20% after \$500; \$250 max/script	
<b>Rx Mail Order</b>	2x retail (100 day supply)		2x retail (100 day supply)	
<b>Home Health Care</b>	No charge; 100 visits/yr		No charge; 100 visits/yr	
<b>Skilled Nursing</b>	40% after ded; 100 days/yr		45% after ded; 100 days/yr	
<b>Infertility Treatment</b>	Not covered		Not covered	
<b>DME</b>	40% ded waived/40% after ded (base/supplemental)		45% ded waived/45% after ded (base/supplemental)	
<b>Hospice Services</b>	No charge		No charge	
<b>Pediatric Vision</b>	No charge; 1 pair/yr		No charge; 1 pair/yr	
<b>Pediatric Dental</b>	Bundled w/copay plan		Bundled w/copay plan	

Formerly Silver 1800/55

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Effective Date: 12-01-2021  
Ames-Grenz

License: 0787081

## Benefit Sheet

Kaiser Silver 70 HMO 2250/55 + Child Dental (Broad Network)		<b>NEW</b> Kaiser Silver 70 HMO 2600/55 + Child Dental Alt (Broad Network)		
Benefit	In Net	Out Net	In Net	Out Net
<b>Individual Ded</b>	\$2,250		\$2,600	
<b>Family Ded</b>	\$4,500 (embedded)		\$5,200 (embedded)	
<b>Individual OOP Max</b>	\$8,200 (incl ded)		\$8,200 (incl ded)	
<b>Family OOP Max</b>	\$16,400 (incl ded)		\$16,400 (incl ded)	
<b>Co-insurance</b>	30%		45%	
<b>Lifetime Max</b>	Unlimited		Unlimited	
<b>PC/Specialist</b>	\$55/\$90 ded waived		\$55/\$80 ded waived	
<b>Adult Preventive Care</b>	No charge		No charge	
<b>Child Preventive Care</b>	No charge		No charge	
<b>Pre/Postnatal Care</b>	No charge		No charge	
<b>Physical Therapy</b>	\$55 ded waived		\$65 ded waived	
<b>Chiropractic Care</b>	Not covered		\$15 ded waived; 20 visits/yr	
<b>Inpatient Hospital</b>	30% after ded		45% after ded	
<b>Inpatient Surgery</b>	N/A		N/A	
<b>Maternity Delivery/IP</b>	30% after ded		45% after ded	
<b>Mental Health IP</b>	30% after ded		45% after ded	
<b>Substance Abuse IP</b>	30% after ded		45% after ded	
<b>Outpatient Facility</b>	30% after ded		45% after ded	
<b>Outpatient Surgery</b>	N/A		N/A	
<b>Lab/X-Ray</b>	\$55/\$90 ded waived		\$30/\$75 after ded	
<b>Advanced Radiology</b>	\$300 after ded		\$350 after ded	
<b>Mental Health OP</b>	\$55 ded waived		\$55 ded waived	
<b>Substance Abuse OP</b>	\$55 ded waived		\$55 ded waived	
<b>Emergency Room</b>	30% after ded		45% after ded	
<b>Ambulance</b>	30% after ded		45% after ded	
<b>Urgent Care</b>	\$55 ded waived		\$55 ded waived	
<b>Rx Generic</b>	\$17 ded waived		\$20 ded waived	
<b>Rx Preferred</b>	\$80 after \$300		\$75 after ded	
<b>Rx Non-Preferred</b>	\$80 after \$300		\$75 after ded	
<b>Rx Specialty</b>	30% after \$300; \$250 max/script		45% after ded; \$250 max/script	
<b>Rx Mail Order</b>	2x retail (100 day supply)		2x retail (100 day supply)	
<b>Home Health Care</b>	\$45 ded waived; 100 visits/yr		No charge; 100 visits/yr	
<b>Skilled Nursing</b>	30% after ded; 100 days/yr		45% after ded; 100 days/yr	
<b>Infertility Treatment</b>	Not covered		Not covered	
<b>DME</b>	30% ded waived/30% after ded (base/supplemental)		45% ded waived/45% after ded (base/supplemental)	
<b>Hospice Services</b>	No charge		No charge	
<b>Pediatric Vision</b>	No charge; 1 pair/yr		No charge; 1 pair/yr	
<b>Pediatric Dental</b>	Bundled w/copay plan		Bundled w/copay plan	

**Formerly Silver 2250/50**

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## Benefit Sheet

Kaiser		<span style="color: red; font-weight: bold;">NEW</span> Kaiser		
Silver 70 HDHP HMO 2500/20% + Child Dental (Broad Network)		Bronze 60 HMO 5400/60 + Child Dental Alt (Broad Network)		
Benefit	In Net	Out Net	In Net	Out Net
<b>Individual Ded</b>	\$2,500 ind only; \$2,800 ind w/family		\$5,400	
<b>Family Ded</b>	\$5,000 (embedded)		\$10,800 (embedded)	
<b>Individual OOP Max</b>	\$6,850 (incl ded)		\$8,200 (incl ded)	
<b>Family OOP Max</b>	\$13,700 (incl ded)		\$16,400 (incl ded)	
<b>Co-insurance</b>	20%		50%	
<b>Lifetime Max</b>	Unlimited		Unlimited	
<b>PC/Specialist</b>	20% after ded		\$60/\$80 ded waived 1st 3 visits	
<b>Adult Preventive Care</b>	No charge		No charge	
<b>Child Preventive Care</b>	No charge		No charge	
<b>Pre/Postnatal Care</b>	No charge		No charge	
<b>Physical Therapy</b>	20% after ded		\$65 ded waived	
<b>Chiropractic Care</b>	Not covered		\$15 ded waived; 20 visits/yr	
<b>Inpatient Hospital</b>	20% after ded		50% after ded	
<b>Inpatient Surgery</b>	N/A		N/A	
<b>Maternity Delivery/IP</b>	20% after ded		50% after ded	
<b>Mental Health IP</b>	20% after ded		50% after ded	
<b>Substance Abuse IP</b>	20% after ded		50% after ded	
<b>Outpatient Facility</b>	20% after ded		50% after ded	
<b>Outpatient Surgery</b>	N/A		N/A	
<b>Lab/X-Ray</b>	20% after ded		\$30/50% after ded	
<b>Advanced Radiology</b>	20% after ded		50% after ded	
<b>Mental Health OP</b>	20% after ded		\$60 ded waived 1st 3 visits	
<b>Substance Abuse OP</b>	20% after ded		\$60 ded waived 1st 3 visits	
<b>Emergency Room</b>	20% after ded		50% after ded	
<b>Ambulance</b>	20% after ded		50% after ded	
<b>Urgent Care</b>	20% after ded		\$60 ded waived 1st 3 visits	
<b>Rx Generic</b>	20% after ded; \$250 max/script		\$20 ded waived	
<b>Rx Preferred</b>	20% after ded; \$250 max/script		50% after ded; \$500 max/script	
<b>Rx Non-Preferred</b>	20% after ded; \$250 max/script		50% after ded; \$500 max/script	
<b>Rx Specialty</b>	20% after ded; \$250 max/script		50% after ded; \$500 max/script	
<b>Rx Mail Order</b>	N/A		2x retail (100 day supply)	
<b>Home Health Care</b>	20% after ded; 100 visits/yr		50% after ded; 100 visits/yr	
<b>Skilled Nursing</b>	20% after ded; 100 days/yr		50% after ded; 100 days/yr	
<b>Infertility Treatment</b>	Not covered		Not covered	
<b>DME</b>	20% after ded (base and supplemental)		50% after ded (base and supplemental)	
<b>Hospice Services</b>	0% after ded		No charge	
<b>Pediatric Vision</b>	No charge; 1 pair/yr		No charge; 1 pair/yr	
<b>Pediatric Dental</b>	Bundled w/copay plan		Bundled w/copay plan	

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## Benefit Sheet

Kaiser Bronze 60 HMO 6300/65 + Child Dental (Broad Network)		Kaiser Bronze 60 HDHP HMO 7000/0% + Child Dental (Broad Network)		
Benefit	In Net	Out Net	In Net	Out Net
<b>Individual Ded</b>	\$6,300		\$7,000	
<b>Family Ded</b>	\$12,600 (embedded)		\$14,000 (embedded)	
<b>Individual OOP Max</b>	\$8,200 (incl ded)		\$7,000 (incl ded)	
<b>Family OOP Max</b>	\$16,400 (incl ded)		\$14,000 (incl ded)	
<b>Co-insurance</b>	40%		0%	
<b>Lifetime Max</b>	Unlimited		Unlimited	
<b>PC/Specialist</b>	\$65/\$95 ded waived 1st 3 visits		0% after ded	
<b>Adult Preventive Care</b>	No charge		No charge	
<b>Child Preventive Care</b>	No charge		No charge	
<b>Pre/Postnatal Care</b>	No charge		No charge	
<b>Physical Therapy</b>	\$65 ded waived		0% after ded	
<b>Chiropractic Care</b>	Not covered		Not covered	
<b>Inpatient Hospital</b>	40% after ded		0% after ded	
<b>Inpatient Surgery</b>	N/A		N/A	
<b>Maternity Delivery/IP</b>	40% after ded		0% after ded	
<b>Mental Health IP</b>	40% after ded		0% after ded	
<b>Substance Abuse IP</b>	40% after ded		0% after ded	
<b>Outpatient Facility</b>	40% after ded		0% after ded	
<b>Outpatient Surgery</b>	N/A		N/A	
<b>Lab/X-Ray</b>	\$40 ded waived/40% after ded		0% after ded	
<b>Advanced Radiology</b>	40% after ded		0% after ded	
<b>Mental Health OP</b>	\$65 ded waived 1st 3 visits		0% after ded	
<b>Substance Abuse OP</b>	\$65 ded waived 1st 3 visits		0% after ded	
<b>Emergency Room</b>	40% after ded		0% after ded	
<b>Ambulance</b>	40% after ded		0% after ded	
<b>Urgent Care</b>	\$65 ded waived 1st 3 visits		0% after ded	
<b>Rx Generic</b>	\$18 after \$500		0% after ded	
<b>Rx Preferred</b>	40% after \$500; \$500 max/script		0% after ded	
<b>Rx Non-Preferred</b>	40% after \$500; \$500 max/script		0% after ded	
<b>Rx Specialty</b>	40% after \$500; \$500 max/script		0% after ded	
<b>Rx Mail Order</b>	2x retail (100 day supply)		N/A	
<b>Home Health Care</b>	40% after ded; 100 visits/yr		0% after ded; 100 visits/yr	
<b>Skilled Nursing</b>	40% after ded; 100 days/yr		0% after ded; 100 days/yr	
<b>Infertility Treatment</b>	Not covered		Not covered	
<b>DME</b>	40% after ded (base and supplemental)		0% after ded (base and supplemental)	
<b>Hospice Services</b>	No charge		0% after ded	
<b>Pediatric Vision</b>	No charge; 1 pair/yr		No charge; 1 pair/yr	
<b>Pediatric Dental</b>	Bundled w/copay plan		Bundled w/copay plan	

Formerly Bronze 6900/0

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# Chiropractic and acupuncture

Combined coverage for chiropractic and acupuncture care is included with the following plans:

- Platinum 90 HMO 0/10 + Child Dental Alt
- Gold 80 HMO 0/30 + Child Dental Alt
- Gold 80 HMO 1000/40 + Child Dental Alt
- Silver 70 HMO 1650/55 + Child Dental Alt
- Silver 70 HMO 2100/55 + Child Dental Alt
- Silver 70 HMO 2600/55 + Child Dental Alt
- Bronze 60 HMO 5400/60 + Child Dental Alt

Services are administered by American Specialty Health Plans of California, Inc®. (ASH Plans).

FEATURES	
Office visit copay	\$15 per visit
Office visit limit	20 combined visits per year
Chiropractic appliance benefit	Chiropractic appliances are provided up to a maximum of \$50 per year when prescribed and provided by an ASH Plans participating chiropractor as part of your chiropractic care.
X-rays and laboratory tests	\$0

## Services

Chiropractic services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. Acupuncture services are covered when a participating acupuncturist finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders, nausea, or pain. You can obtain services from any ASH Plans participating chiropractors and acupuncturists without a referral from a Kaiser Permanente Plan physician.

**Office visits:** Covered services are limited to medically necessary chiropractic and acupuncture services authorized and provided by ASH Plans participating chiropractors and acupuncturists.

**X-rays and laboratory tests:** Medically necessary X-rays and laboratory tests are covered when prescribed as part of your chiropractic care by a participating chiropractor and provided by an appropriately licensed participating provider that has contracted with ASH Plans to provide those services.

**Emergency services:** Covered chiropractic services are those emergency services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system. Covered acupuncture services are those emergency services provided for the sudden and unexpected treatment of a neuromusculoskeletal disorder, nausea, or pain. These conditions and injuries must manifest themselves by acute symptoms of sufficient severity, including severe pain, such that a reasonable layperson with no special knowledge of health, medicine, chiropractic care, or acupuncture could reasonably expect that a delay of immediate chiropractic care or acupuncture could result in (1) placing your health in serious jeopardy, (2) serious impairment to your bodily functions, or (3) serious dysfunction of any bodily organ or part.

## Participating chiropractors and acupuncturists

ASH Plans contracts with participating chiropractors and other participating providers to provide covered chiropractic services, including laboratory tests, X-rays, and chiropractic appliances. ASH Plans

contracts with participating acupuncturists to provide acupuncture care (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered services from an ASH Plans participating provider, except for emergency chiropractic and acupuncture services and services that aren't available from participating providers that are previously authorized by ASH Plans. The list of participating chiropractors and acupuncturists is available on the ASH Plans website at [ashlink.com/ash/kp](http://ashlink.com/ash/kp) or from the ASH Plans Member Services Department at **800-678-9133**. The list of participating chiropractors and acupuncturists is subject to change at any time without notice.

### How to obtain covered services

To obtain covered services, schedule an initial examination with an ASH Plans participating provider. If additional services are required, your participating chiropractor or acupuncturist will prepare a treatment plan. The ASH Plans Clinical Services Manager will authorize the treatment plan if the services are medically necessary. ASH Plans will disclose to you, upon request, the process that it uses to authorize a treatment plan. If you have questions or concerns, please contact the ASH Plans Member Services Department.

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including copays. Please refer to the *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic and acupuncture benefits, including exclusions and limitations, emergency chiropractic services, and emergency acupuncture services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of participating chiropractors and participating acupuncturists available to you. You can obtain covered services from any participating chiropractor or participating acupuncturist without a referral from a Plan physician. Cost sharing is due when you receive covered services. Please see the definitions section of your *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

### Getting assistance

If you have a question or concern regarding the services you received from a participating provider, you may call ASH Plans Member Services at **800-678-9133** (TTY users, call **711**), weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans Member Services  
P.O. Box 509002  
San Diego, CA 92150-9002

### Dispute resolution

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as why you believe a decision was in error or why you're dissatisfied with services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Evidence of Coverage*.

# CHILD DENTAL PLAN FOR KAISER PERMANENTE HMO MEDICAL PLANS

Child dental services is one of the essential health benefits required to be provided in conjunction with your Affordable Care Act (ACA) metal medical plan(s). When employees and their dependents enroll in the HMO medical plan(s) you've chosen, we'll also enroll them in a separate child dental plan underwritten by Delta Dental of California. Child dental benefits for HMO members are provided through the DeltaCare USA network.

FEATURES	MEMBER PAYS
<b>DEDUCTIBLE</b>	\$0
<b>OUT-OF-POCKET (OOP) MAXIMUM</b>	\$350/child \$700/multichild
<b>WAITING PERIODS</b>	None
<b>OFFICE VISIT</b>	\$0
<b>DIAGNOSTIC AND PREVENTIVE</b>	
Periodic and comprehensive – oral evaluation	\$0
Bitewing X-rays	\$0
Prophylaxis cleaning	\$0
Fluoride treatments	\$0
Space maintainers	\$0
Sealant repair	\$0
<b>PERIODONTICS</b>	
Maintenance	\$30
Scaling and root planing	\$30
Surgery – osseous (includes flap entry and closure)	\$265
<b>RESTORATIVE</b>	
Fillings – primary or permanent amalgam	\$25
Composite crowns – resin-based one surface anterior	\$30
Crown – porcelain	\$300
<b>ENDODONTICS</b>	
Therapeutic pulpotomy	\$40
Root canal – anterior	\$195
Root canal – molar	\$300
<b>PROSTHODONTICS</b>	
Complete denture	\$300
Reline maxillary denture – chairside and limitations is "Partial"	\$60
Reline maxillary denture – laboratory and limitations is "Partial"	\$90
<b>ORAL AND MAXILLOFACIAL SURGERY</b>	
Extraction – erupted tooth or exposed root	\$65
Surgical removal of erupted tooth	\$120
<b>ORTHODONTICS (MEDICALLY NECESSARY)</b>	\$350*

## Important information

- To find a dentist, please call Delta Dental at **1-800-422-4234**.
- You choose a Delta Dental dentist for each child. If you don't choose a dentist, we assign one to you.
- As soon as you receive your welcome kit, you can schedule an appointment. You can change your selected network dentist at any time by telephone. Changes received by the 21st of the month will be effective the first day of the following month.
- If you require specialty care, your Delta Dental dentist will coordinate it for you.

\*Orthodontics includes medically necessary orthodontia only.

# KAISER PERMANENTE PEDIATRIC VISION CARE

(Services only rendered at Kaiser Permanente for Kaiser Permanente Vision Essentials)

Affordable Care Act (ACA)–qualified health plans include vision benefits and medical care from trusted Kaiser Permanente optometrists and ophthalmologists. You can connect vision care to overall health with Vision Essentials by Kaiser Permanente. Because our optometrists and ophthalmologists work with our integrated care system, they're connected to our larger team of medical professionals. Regular eye exams can detect not only vision problems, but symptoms of other important health issues.

Services must be performed and provided by a Kaiser Permanente provider for children who are under the age of 19 and are covered under an ACA metal plan. They'll have their choice of either regular clear eyeglasses or contact lenses from the Value Collection to serve their vision needs.

FEATURES	MEMBER PAYS
<b>ROUTINE VISION EXAM<sup>1</sup></b>	\$0
<b>EYEGLOSS OPTION<sup>2</sup></b> Yearly eye exam with refraction Regular clear eyeglasses (Value Collection frame and lenses only)	\$0 \$0
<b>CONTACT LENS OPTION<sup>3</sup></b> Yearly eye exam with refraction Contact lens fitting fees One pair of standard or disposable contact lenses	\$0 \$0 \$0

<sup>1</sup>Schedule a routine eye exam with a plan optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses **(not subject to the plan deductible)**.

<sup>2</sup>If you prefer to wear eyeglasses rather than contact lenses, we cover one complete pair of eyeglasses (frame and regular eyeglass lenses) from our designated value frame collection **(not subject to the plan deductible)** every 12 months when prescribed by a physician or optometrist and a plan provider puts the lenses into an eyeglass frame.

<sup>3</sup>If you prefer to wear contact lenses rather than eyeglasses, we cover one of the following, including fitting and dispensing, **(not subject to the plan deductible)** when prescribed by a physician or optometrist and obtained at a plan medical office or plan optical sales office:

- Standard contact lenses: one pair of lenses in any 12-month period
- Disposable contact lenses: one 6-month supply for each eye in any 12-month period

#### Important Information

To find locations, products, and services for metal plans, go to [kp.org/2020](https://kp.org/2020).

For further detailed information on pediatric vision, refer to your *Combined Disclosure Form and Evidence of Coverage*.

**2021 Service Area County + ZIP Codes for Metal Plans**

There are 19 geographical rate areas. The rating areas for metal plans are based on the employer's physical, authenticated address and defined using county boundaries (valid ZIP+4 code and county), regardless if a group is located outside the Kaiser Permanente service area in California. If a group is located out of a state, then rating area 4 is assigned. When a group is located outside the Kaiser Permanente service area in California or out of state, then only employees living in the service area are eligible to enroll based on their home ZIP code + county.

County	Rate Area	County + Zip Code Combinations in Kaiser Permanente Service Area										
Alameda	6	94501-02	94536-46	94557	94568	94601-15	94659-62	94712	95391			
		94505	94550-52	94560	94577-80	94617-24	94666	94720				
		94514	94555	94566	94586-88	94649	94701-10	95377				
Contra Costa	5	94505-07	94511	94516-31	94551	94556	94563-65	94572	94582-83	94706-08	94820	
		94509	94513-14	94547-49	94553	94561	94569-70	94575	94595-98	94801-08	94850	
Marin	2	94901	94912-15	94924-25	94933	94945-50	94956-57	94963-66	94973-74			
		94903-04	94920	94929-30	94937-42	94952	94960	94970-71	94976-79			
Napa	2	94503	94515	94562	94573-74	94581	95476					
		94508	94558-59	94567	94576	94599						
San Francisco	4	94102-05	94114-34	94139-47	94158-61	94172	94188					
		94107-12	94137	94151	94163-64	94177						
San Mateo	8	94002	94010-11	94025-28	94037-38	94060-66	94074	94083	94303	94497		
		94005	94014-21	94030	94044	94070	94080	94128	94401-04			
Santa Clara	7	94022-24	94301-06	95008-09	95026	95044	95076	95108-13	95150-61	95190-94		
		94035	94309	95011	95030-33	95046	95101	95115-36	95164	95196		
		94039-43	94550	95013-15	95035-38	95050-56	95103	95138-41	95170			
		94085-89	95002	95020-21	95042	95070-71	95106	95148	95172-73			
Solano	2	94503	94512	94571	94589-92	95618	95625	95690	95696			
		94510	94533-35	94585	95616	95620	95687-88	95694				
Sonoma	2	94515	94931	94975	95409	95421	95433	95441-42	95448	95462	95476	
		94922-23	94951-55	94999	95416	95425	95436	95444	95450	95465	95486-87	
		94926-28	94972	95401-07	95419	95430-31	95439	95446	95452	95471-73	95492	

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/20* + Child Dental Formerly 0/15	Gold 80 HMO 0/30* + Child Dental Alt	Gold 80 HMO 250/35* + Child Dental Formerly 250/25 Replaced 500/30	Gold 80 HMO 1000/40* + Child Dental Alt NEW Plan	Gold 80 HRA HMO 2250/35 + Child Dental
0-14†	\$336.67	\$330.81	\$315.62	\$298.73	\$282.91	\$267.20
15†	\$365.36	\$358.98	\$342.44	\$324.04	\$306.82	\$289.70
16†	\$376.32	\$369.74	\$352.69	\$333.72	\$315.96	\$298.31
17†	\$387.29	\$380.51	\$362.94	\$343.40	\$325.10	\$306.92
18†	\$399.10	\$392.11	\$373.98	\$353.82	\$334.94	\$316.18
19	\$396.92	\$389.71	\$371.03	\$350.25	\$330.79	\$311.46
20	\$409.16	\$401.72	\$382.46	\$361.05	\$340.99	\$321.06
21	\$421.81	\$414.15	\$394.29	\$372.21	\$351.53	\$330.99
22	\$421.81	\$414.15	\$394.29	\$372.21	\$351.53	\$330.99
23	\$421.81	\$414.15	\$394.29	\$372.21	\$351.53	\$330.99
24	\$421.81	\$414.15	\$394.29	\$372.21	\$351.53	\$330.99
25	\$423.50	\$415.81	\$395.87	\$373.70	\$352.94	\$332.31
26	\$431.93	\$424.09	\$403.76	\$381.15	\$359.97	\$338.93
27	\$442.06	\$434.03	\$413.22	\$390.08	\$368.41	\$346.88
28	\$458.51	\$450.18	\$428.60	\$404.59	\$382.12	\$359.79
29	\$472.00	\$463.43	\$441.21	\$416.51	\$393.37	\$370.38
30	\$478.75	\$470.06	\$447.52	\$422.46	\$398.99	\$375.67
31	\$488.88	\$480.00	\$456.99	\$431.39	\$407.43	\$383.62
32	\$499.00	\$489.94	\$466.45	\$440.33	\$415.87	\$391.56
33	\$505.33	\$496.15	\$472.36	\$445.91	\$421.14	\$396.52
34	\$512.08	\$502.78	\$478.67	\$451.87	\$426.76	\$401.82
35	\$515.45	\$506.09	\$481.83	\$454.84	\$429.58	\$404.47
36	\$518.83	\$509.40	\$484.98	\$457.82	\$432.39	\$407.12
37	\$522.20	\$512.72	\$488.14	\$460.80	\$435.20	\$409.76
38	\$525.57	\$516.03	\$491.29	\$463.78	\$438.01	\$412.41
39	\$532.32	\$522.66	\$497.60	\$469.73	\$443.64	\$417.71
40	\$539.07	\$529.28	\$503.91	\$475.69	\$449.26	\$423.00
41	\$549.20	\$539.22	\$513.37	\$484.62	\$457.70	\$430.95
42	\$558.90	\$548.75	\$522.44	\$493.18	\$465.78	\$438.56
43	\$572.40	\$562.00	\$535.06	\$505.09	\$477.03	\$449.15
44	\$589.27	\$578.57	\$550.83	\$519.98	\$491.09	\$462.39
45	\$609.09	\$598.03	\$569.36	\$537.47	\$507.62	\$477.95
46	\$632.71	\$621.22	\$591.44	\$558.32	\$527.30	\$496.48
47	\$659.29	\$647.31	\$616.28	\$581.77	\$549.45	\$517.34
48	\$689.66	\$677.13	\$644.67	\$608.57	\$574.76	\$541.17
49	\$719.61	\$706.54	\$672.67	\$634.99	\$599.72	\$564.67
50	\$753.35	\$739.67	\$704.21	\$664.77	\$627.84	\$591.15
51	\$786.67	\$772.39	\$735.36	\$694.18	\$655.61	\$617.29
52	\$823.37	\$808.42	\$769.66	\$726.56	\$686.20	\$646.09
53	\$860.49	\$844.86	\$804.36	\$759.31	\$717.13	\$675.22
54	\$900.56	\$884.21	\$841.82	\$794.67	\$750.53	\$706.66
55	\$940.64	\$923.55	\$879.27	\$830.03	\$783.92	\$738.11
56	\$984.08	\$966.21	\$919.89	\$868.37	\$820.13	\$772.20
57	\$1,027.95	\$1,009.28	\$960.89	\$907.08	\$856.69	\$806.62
58	\$1,074.77	\$1,055.25	\$1,004.66	\$948.40	\$895.71	\$843.36
59	\$1,097.97	\$1,078.03	\$1,026.35	\$968.87	\$915.04	\$861.56
60	\$1,144.79	\$1,124.00	\$1,070.11	\$1,010.18	\$954.07	\$898.30
61	\$1,185.28	\$1,163.76	\$1,107.97	\$1,045.92	\$987.81	\$930.08
62	\$1,211.86	\$1,189.85	\$1,132.81	\$1,069.37	\$1,009.96	\$950.93
63	\$1,245.18	\$1,222.57	\$1,163.95	\$1,098.77	\$1,037.73	\$977.08
64+	\$1,265.43	\$1,242.45	\$1,182.87	\$1,116.63	\$1,054.59	\$992.97

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

Age on 2021 effective date	Silver 70 HMO 1650/55* + Child Dental Alt	Silver 70 HMO 2100/55* + Child Dental Alt Formerly 1800/55	Silver 70 HMO 2250/55* + Child Dental Formerly 2250/50	Silver 70 HMO 2600/55* + Child Dental Alt NEW Plan	Silver 70 HDHP HMO 2500/20%* + Child Dental
0-14†	\$257.48	\$253.06	\$255.75	\$249.05	\$237.58
15†	\$279.13	\$274.31	\$277.24	\$269.95	\$257.45
16†	\$287.40	\$282.44	\$285.46	\$277.94	\$265.05
17†	\$295.68	\$290.56	\$293.68	\$285.93	\$272.65
18†	\$304.59	\$299.31	\$302.53	\$294.53	\$280.83
19	\$299.51	\$294.07	\$297.39	\$289.14	\$275.03
20	\$308.74	\$303.14	\$306.55	\$298.06	\$283.50
21	\$318.29	\$312.51	\$316.03	\$307.27	\$292.27
22	\$318.29	\$312.51	\$316.03	\$307.27	\$292.27
23	\$318.29	\$312.51	\$316.03	\$307.27	\$292.27
24	\$318.29	\$312.51	\$316.03	\$307.27	\$292.27
25	\$319.56	\$313.76	\$317.30	\$308.50	\$293.44
26	\$325.93	\$320.01	\$323.62	\$314.65	\$299.29
27	\$333.57	\$327.51	\$331.20	\$322.02	\$306.30
28	\$345.98	\$339.70	\$343.53	\$334.01	\$317.70
29	\$356.17	\$349.70	\$353.64	\$343.84	\$327.05
30	\$361.26	\$354.70	\$358.70	\$348.76	\$331.73
31	\$368.90	\$362.20	\$366.28	\$356.13	\$338.74
32	\$376.54	\$369.70	\$373.86	\$363.51	\$345.76
33	\$381.31	\$374.39	\$378.61	\$368.11	\$350.14
34	\$386.41	\$379.39	\$383.66	\$373.03	\$354.82
35	\$388.95	\$381.89	\$386.19	\$375.49	\$357.16
36	\$391.50	\$384.39	\$388.72	\$377.95	\$359.49
37	\$394.05	\$386.89	\$391.25	\$380.41	\$361.83
38	\$396.59	\$389.39	\$393.77	\$382.86	\$364.17
39	\$401.68	\$394.39	\$398.83	\$387.78	\$368.85
40	\$406.78	\$399.39	\$403.89	\$392.70	\$373.52
41	\$414.42	\$406.89	\$411.47	\$400.07	\$380.54
42	\$421.74	\$414.08	\$418.74	\$407.14	\$387.26
43	\$431.92	\$424.08	\$428.85	\$416.97	\$396.61
44	\$444.65	\$436.58	\$441.50	\$429.26	\$408.30
45	\$459.61	\$451.27	\$456.35	\$443.70	\$422.04
46	\$477.44	\$468.77	\$474.05	\$460.91	\$438.41
47	\$497.49	\$488.46	\$493.96	\$480.27	\$456.82
48	\$520.41	\$510.96	\$516.71	\$502.39	\$477.86
49	\$543.01	\$533.15	\$539.15	\$524.21	\$498.62
50	\$568.47	\$558.15	\$564.43	\$548.79	\$522.00
51	\$593.61	\$582.84	\$589.40	\$573.07	\$545.09
52	\$621.31	\$610.02	\$616.89	\$599.80	\$570.51
53	\$649.31	\$637.52	\$644.70	\$626.84	\$596.23
54	\$679.55	\$667.21	\$674.73	\$656.03	\$624.00
55	\$709.79	\$696.90	\$704.75	\$685.22	\$651.77
56	\$742.57	\$729.09	\$737.30	\$716.87	\$681.87
57	\$775.68	\$761.59	\$770.17	\$748.83	\$712.27
58	\$811.01	\$796.28	\$805.25	\$782.93	\$744.71
59	\$828.51	\$813.47	\$822.63	\$799.83	\$760.78
60	\$863.84	\$848.16	\$857.71	\$833.94	\$793.23
61	\$894.40	\$878.16	\$888.05	\$863.44	\$821.28
62	\$914.45	\$897.85	\$907.96	\$882.80	\$839.70
63	\$939.60	\$922.54	\$932.92	\$907.07	\$862.79
64+	\$954.87	\$937.53	\$948.09	\$921.81	\$876.81

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Bronze 60 HMO 5400/60* + Child Dental Alt <b>NEW Plan</b>	Bronze 60 HMO 6300/65* + Child Dental	Bronze 60 HDHP HMO 7000/0* + Child Dental <b>Formerly 6900/0</b>
0-14 <sup>†</sup>	\$216.19	\$220.24	\$207.06
15 <sup>†</sup>	\$234.17	\$238.57	\$224.23
16 <sup>†</sup>	\$241.04	\$245.58	\$230.79
17 <sup>†</sup>	\$247.91	\$252.59	\$237.35
18 <sup>†</sup>	\$255.31	\$260.14	\$244.42
19	\$248.72	\$253.70	\$237.49
20	\$256.39	\$261.52	\$244.81
21	\$264.32	\$269.60	\$252.38
22	\$264.32	\$269.60	\$252.38
23	\$264.32	\$269.60	\$252.38
24	\$264.32	\$269.60	\$252.38
25	\$265.37	\$270.68	\$253.39
26	\$270.66	\$276.07	\$258.44
27	\$277.00	\$282.55	\$264.50
28	\$287.31	\$293.06	\$274.34
29	\$295.77	\$301.69	\$282.42
30	\$300.00	\$306.00	\$286.46
31	\$306.34	\$312.47	\$292.51
32	\$312.69	\$318.94	\$298.57
33	\$316.65	\$322.99	\$302.36
34	\$320.88	\$327.30	\$306.40
35	\$323.00	\$329.46	\$308.41
36	\$325.11	\$331.61	\$310.43
37	\$327.23	\$333.77	\$312.45
38	\$329.34	\$335.93	\$314.47
39	\$333.57	\$340.24	\$318.51
40	\$337.80	\$344.55	\$322.55
41	\$344.14	\$351.02	\$328.60
42	\$350.22	\$357.23	\$334.41
43	\$358.68	\$365.85	\$342.49
44	\$369.25	\$376.64	\$352.58
45	\$381.67	\$389.31	\$364.44
46	\$396.48	\$404.41	\$378.58
47	\$413.13	\$421.39	\$394.48
48	\$432.16	\$440.80	\$412.65
49	\$450.93	\$459.94	\$430.57
50	\$472.07	\$481.51	\$450.76
51	\$492.95	\$502.81	\$470.70
52	\$515.95	\$526.27	\$492.66
53	\$539.21	\$549.99	\$514.86
54	\$564.32	\$575.60	\$538.84
55	\$589.43	\$601.22	\$562.82
56	\$616.65	\$628.99	\$588.81
57	\$644.14	\$657.03	\$615.06
58	\$673.48	\$686.95	\$643.08
59	\$688.02	\$701.78	\$656.96
60	\$717.36	\$731.71	\$684.97
61	\$742.73	\$757.59	\$709.20
62	\$759.38	\$774.57	\$725.10
63	\$780.27	\$795.87	\$745.04
64+	\$792.96	\$808.80	\$757.14

<sup>†</sup>HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.



A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/20* + Child Dental Formerly 0/15	Gold 80 HMO 0/30* + Child Dental Alt	Gold 80 HMO 250/35* + Child Dental Formerly 250/25 Replaced 500/30	Gold 80 HMO 1000/40* + Child Dental Alt NEW Plan	Gold 80 HRA HMO 2250/35 + Child Dental
0-14†	\$353.66	\$347.49	\$331.50	\$313.72	\$297.07	\$280.52
15†	\$383.85	\$377.13	\$359.72	\$340.36	\$322.23	\$304.22
16†	\$395.39	\$388.47	\$370.51	\$350.55	\$331.85	\$313.27
17†	\$406.94	\$399.80	\$381.31	\$360.74	\$341.47	\$322.33
18†	\$419.37	\$412.01	\$392.93	\$371.71	\$351.83	\$332.09
19	\$417.81	\$410.23	\$390.56	\$368.69	\$348.20	\$327.85
20	\$430.69	\$422.87	\$402.59	\$380.05	\$358.94	\$337.96
21	\$444.01	\$435.95	\$415.05	\$391.80	\$370.04	\$348.41
22	\$444.01	\$435.95	\$415.05	\$391.80	\$370.04	\$348.41
23	\$444.01	\$435.95	\$415.05	\$391.80	\$370.04	\$348.41
24	\$444.01	\$435.95	\$415.05	\$391.80	\$370.04	\$348.41
25	\$445.79	\$437.69	\$416.71	\$393.37	\$371.52	\$349.80
26	\$454.67	\$446.41	\$425.01	\$401.21	\$378.92	\$356.77
27	\$465.32	\$456.87	\$434.97	\$410.61	\$387.80	\$365.13
28	\$482.64	\$473.87	\$451.15	\$425.89	\$402.23	\$378.72
29	\$496.85	\$487.82	\$464.44	\$438.43	\$414.07	\$389.87
30	\$503.95	\$494.80	\$471.08	\$444.70	\$419.99	\$395.44
31	\$514.61	\$505.26	\$481.04	\$454.10	\$428.87	\$403.81
32	\$525.26	\$515.72	\$491.00	\$463.50	\$437.75	\$412.17
33	\$531.92	\$522.26	\$497.23	\$469.38	\$443.30	\$417.39
34	\$539.03	\$529.24	\$503.87	\$475.65	\$449.22	\$422.97
35	\$542.58	\$532.73	\$507.19	\$478.78	\$452.18	\$425.76
36	\$546.13	\$536.21	\$510.51	\$481.92	\$455.14	\$428.54
37	\$549.68	\$539.70	\$513.83	\$485.05	\$458.11	\$431.33
38	\$553.24	\$543.19	\$517.15	\$488.19	\$461.07	\$434.12
39	\$560.34	\$550.16	\$523.79	\$494.45	\$466.99	\$439.69
40	\$567.44	\$557.14	\$530.43	\$500.72	\$472.91	\$445.27
41	\$578.10	\$567.60	\$540.39	\$510.13	\$481.79	\$453.63
42	\$588.31	\$577.63	\$549.94	\$519.14	\$490.30	\$461.64
43	\$602.52	\$591.58	\$563.22	\$531.68	\$502.14	\$472.79
44	\$620.28	\$609.02	\$579.82	\$547.35	\$516.94	\$486.73
45	\$641.15	\$629.51	\$599.33	\$565.76	\$534.33	\$503.10
46	\$666.02	\$653.92	\$622.57	\$587.70	\$555.05	\$522.61
47	\$693.99	\$681.38	\$648.72	\$612.39	\$578.37	\$544.56
48	\$725.96	\$712.77	\$678.60	\$640.60	\$605.01	\$569.65
49	\$757.48	\$743.72	\$708.07	\$668.41	\$631.28	\$594.39
50	\$793.00	\$778.60	\$741.27	\$699.76	\$660.89	\$622.26
51	\$828.08	\$813.04	\$774.06	\$730.71	\$690.12	\$649.78
52	\$866.71	\$850.97	\$810.17	\$764.80	\$722.31	\$680.10
53	\$905.78	\$889.33	\$846.69	\$799.28	\$754.87	\$710.76
54	\$947.96	\$930.75	\$886.12	\$836.50	\$790.03	\$743.85
55	\$990.14	\$972.16	\$925.55	\$873.72	\$825.18	\$776.95
56	\$1,035.88	\$1,017.06	\$968.30	\$914.07	\$863.30	\$812.84
57	\$1,082.05	\$1,062.40	\$1,011.47	\$954.82	\$901.78	\$849.07
58	\$1,131.34	\$1,110.79	\$1,057.54	\$998.31	\$942.85	\$887.75
59	\$1,155.76	\$1,134.77	\$1,080.36	\$1,019.86	\$963.21	\$906.91
60	\$1,205.04	\$1,183.16	\$1,126.43	\$1,063.35	\$1,004.28	\$945.58
61	\$1,247.67	\$1,225.01	\$1,166.28	\$1,100.96	\$1,039.80	\$979.03
62	\$1,275.64	\$1,252.47	\$1,192.43	\$1,125.65	\$1,063.12	\$1,000.98
63	\$1,310.72	\$1,286.91	\$1,225.22	\$1,156.60	\$1,092.35	\$1,028.50
64+	\$1,332.03	\$1,307.85	\$1,245.15	\$1,175.40	\$1,110.12	\$1,045.23

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Silver 70 HMO 1650/55* + Child Dental Alt	Silver 70 HMO 2100/55* + Child Dental Alt Formerly 1800/55	Silver 70 HMO 2250/55* + Child Dental Formerly 2250/50	Silver 70 HMO 2600/55* + Child Dental Alt NEW Plan	Silver 70 HDHP HMO 2500/20%* + Child Dental
0-14 <sup>†</sup>	\$270.30	\$265.64	\$268.48	\$261.43	\$249.35
15 <sup>†</sup>	\$293.08	\$288.01	\$291.10	\$283.42	\$270.27
16 <sup>†</sup>	\$301.79	\$296.57	\$299.75	\$291.83	\$278.27
17 <sup>†</sup>	\$310.50	\$305.12	\$308.40	\$300.24	\$286.26
18 <sup>†</sup>	\$319.89	\$314.33	\$317.71	\$309.30	\$294.88
19	\$315.28	\$309.55	\$313.04	\$304.36	\$289.50
20	\$324.99	\$319.09	\$322.68	\$313.74	\$298.43
21	\$335.04	\$328.96	\$332.66	\$323.45	\$307.65
22	\$335.04	\$328.96	\$332.66	\$323.45	\$307.65
23	\$335.04	\$328.96	\$332.66	\$323.45	\$307.65
24	\$335.04	\$328.96	\$332.66	\$323.45	\$307.65
25	\$336.38	\$330.28	\$334.00	\$324.74	\$308.89
26	\$343.08	\$336.86	\$340.65	\$331.21	\$315.04
27	\$351.13	\$344.75	\$348.63	\$338.97	\$322.42
28	\$364.19	\$357.58	\$361.61	\$351.59	\$334.42
29	\$374.91	\$368.11	\$372.25	\$361.94	\$344.27
30	\$380.27	\$373.37	\$377.57	\$367.11	\$349.19
31	\$388.32	\$381.26	\$385.56	\$374.87	\$356.57
32	\$396.36	\$389.16	\$393.54	\$382.64	\$363.96
33	\$401.38	\$394.09	\$398.53	\$387.49	\$368.57
34	\$406.74	\$399.36	\$403.85	\$392.66	\$373.49
35	\$409.42	\$401.99	\$406.52	\$395.25	\$375.95
36	\$412.10	\$404.62	\$409.18	\$397.84	\$378.42
37	\$414.78	\$407.25	\$411.84	\$400.43	\$380.88
38	\$417.46	\$409.88	\$414.50	\$403.01	\$383.34
39	\$422.83	\$415.15	\$419.82	\$408.19	\$388.26
40	\$428.19	\$420.41	\$425.15	\$413.36	\$393.18
41	\$436.23	\$428.31	\$433.13	\$421.13	\$400.57
42	\$443.93	\$435.87	\$440.78	\$428.57	\$407.64
43	\$454.65	\$446.40	\$451.43	\$438.92	\$417.49
44	\$468.06	\$459.56	\$464.73	\$451.85	\$429.79
45	\$483.80	\$475.02	\$480.37	\$467.06	\$444.25
46	\$502.57	\$493.44	\$499.00	\$485.17	\$461.48
47	\$523.67	\$514.16	\$519.95	\$505.55	\$480.86
48	\$547.80	\$537.85	\$543.91	\$528.83	\$503.02
49	\$571.58	\$561.21	\$567.53	\$551.80	\$524.86
50	\$598.39	\$587.52	\$594.14	\$577.68	\$549.47
51	\$624.86	\$613.51	\$620.42	\$603.23	\$573.78
52	\$654.01	\$642.13	\$649.36	\$631.37	\$600.54
53	\$683.49	\$671.08	\$678.64	\$659.83	\$627.62
54	\$715.32	\$702.33	\$710.24	\$690.56	\$656.84
55	\$747.15	\$733.58	\$741.84	\$721.29	\$686.07
56	\$781.66	\$767.46	\$776.11	\$754.60	\$717.76
57	\$816.50	\$801.68	\$810.70	\$788.24	\$749.75
58	\$853.69	\$838.19	\$847.63	\$824.14	\$783.90
59	\$872.12	\$856.28	\$865.93	\$841.93	\$800.83
60	\$909.31	\$892.80	\$902.85	\$877.83	\$834.98
61	\$941.47	\$924.38	\$934.79	\$908.88	\$864.51
62	\$962.58	\$945.10	\$955.74	\$929.26	\$883.89
63	\$989.05	\$971.09	\$982.03	\$954.81	\$908.20
64+	\$1,005.12	\$986.88	\$997.98	\$970.35	\$922.95

<sup>†</sup>HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Bronze 60 HMO 5400/60* + Child Dental Alt <b>NEW Plan</b>	Bronze 60 HMO 6300/65* + Child Dental	Bronze 60 HDHP HMO 7000/0* + Child Dental <b>Formerly 6900/0</b>
0-14 <sup>†</sup>	\$226.84	\$231.09	\$217.23
15 <sup>†</sup>	\$245.75	\$250.39	\$235.29
16 <sup>†</sup>	\$252.99	\$257.77	\$242.20
17 <sup>†</sup>	\$260.22	\$265.15	\$249.11
18 <sup>†</sup>	\$268.01	\$273.09	\$256.55
19	\$261.81	\$267.05	\$249.99
20	\$269.88	\$275.28	\$257.70
21	\$278.23	\$283.79	\$265.67
22	\$278.23	\$283.79	\$265.67
23	\$278.23	\$283.79	\$265.67
24	\$278.23	\$283.79	\$265.67
25	\$279.34	\$284.93	\$266.73
26	\$284.91	\$290.60	\$272.04
27	\$291.58	\$297.42	\$278.42
28	\$302.43	\$308.48	\$288.78
29	\$311.34	\$317.57	\$297.28
30	\$315.79	\$322.11	\$301.53
31	\$322.47	\$328.92	\$307.91
32	\$329.14	\$335.73	\$314.29
33	\$333.32	\$339.98	\$318.27
34	\$337.77	\$344.53	\$322.52
35	\$340.00	\$346.80	\$324.65
36	\$342.22	\$349.07	\$326.77
37	\$344.45	\$351.34	\$328.90
38	\$346.67	\$353.61	\$331.02
39	\$351.12	\$358.15	\$335.27
40	\$355.58	\$362.69	\$339.52
41	\$362.25	\$369.50	\$345.90
42	\$368.65	\$376.03	\$352.01
43	\$377.56	\$385.11	\$360.51
44	\$388.69	\$396.46	\$371.14
45	\$401.76	\$409.80	\$383.62
46	\$417.34	\$425.69	\$398.50
47	\$434.87	\$443.57	\$415.24
48	\$454.90	\$464.00	\$434.37
49	\$474.66	\$484.15	\$453.23
50	\$496.92	\$506.86	\$474.48
51	\$518.90	\$529.28	\$495.47
52	\$543.10	\$553.97	\$518.58
53	\$567.59	\$578.94	\$541.96
54	\$594.02	\$605.90	\$567.20
55	\$620.45	\$632.86	\$592.44
56	\$649.11	\$662.09	\$619.80
57	\$678.04	\$691.61	\$647.43
58	\$708.93	\$723.11	\$676.92
59	\$724.23	\$738.72	\$691.53
60	\$755.11	\$770.22	\$721.02
61	\$781.82	\$797.46	\$746.53
62	\$799.35	\$815.34	\$763.26
63	\$821.33	\$837.76	\$784.25
64+	\$834.69	\$851.37	\$797.01

<sup>†</sup>HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/20* + Child Dental Formerly 0/15	Gold 80 HMO 0/30* + Child Dental Alt	Gold 80 HMO 250/35* + Child Dental Formerly 250/25 Replaced 500/30	Gold 80 HMO 1000/40* + Child Dental Alt NEW Plan	Gold 80 HRA HMO 2250/35 + Child Dental
0-14†	\$370.64	\$364.16	\$347.38	\$328.71	\$311.22	\$293.85
15†	\$402.34	\$395.29	\$377.01	\$356.68	\$337.64	\$318.73
16†	\$414.46	\$407.19	\$388.34	\$367.38	\$347.74	\$328.24
17†	\$426.59	\$419.09	\$399.67	\$378.07	\$357.85	\$337.75
18†	\$439.64	\$431.91	\$411.87	\$389.59	\$368.73	\$347.99
19	\$438.70	\$430.74	\$410.09	\$387.12	\$365.61	\$344.25
20	\$452.22	\$444.01	\$422.72	\$399.05	\$376.88	\$354.86
21	\$466.21	\$457.74	\$435.80	\$411.39	\$388.54	\$365.83
22	\$466.21	\$457.74	\$435.80	\$411.39	\$388.54	\$365.83
23	\$466.21	\$457.74	\$435.80	\$411.39	\$388.54	\$365.83
24	\$466.21	\$457.74	\$435.80	\$411.39	\$388.54	\$365.83
25	\$468.08	\$459.57	\$437.54	\$413.04	\$390.09	\$367.29
26	\$477.40	\$468.73	\$446.26	\$421.27	\$397.86	\$374.61
27	\$488.59	\$479.72	\$456.72	\$431.14	\$407.19	\$383.39
28	\$506.77	\$497.57	\$473.71	\$447.18	\$422.34	\$397.66
29	\$521.69	\$512.22	\$487.66	\$460.35	\$434.77	\$409.36
30	\$529.15	\$519.54	\$494.63	\$466.93	\$440.99	\$415.22
31	\$540.34	\$530.52	\$505.09	\$476.80	\$450.32	\$424.00
32	\$551.53	\$541.51	\$515.55	\$486.68	\$459.64	\$432.78
33	\$558.52	\$548.38	\$522.09	\$492.85	\$465.47	\$438.26
34	\$565.98	\$555.70	\$529.06	\$499.43	\$471.69	\$444.12
35	\$569.71	\$559.36	\$532.55	\$502.72	\$474.79	\$447.04
36	\$573.44	\$563.02	\$536.03	\$506.01	\$477.90	\$449.97
37	\$577.17	\$566.69	\$539.52	\$509.30	\$481.01	\$452.90
38	\$580.90	\$570.35	\$543.00	\$512.60	\$484.12	\$455.82
39	\$588.36	\$577.67	\$549.98	\$519.18	\$490.34	\$461.68
40	\$595.82	\$585.00	\$556.95	\$525.76	\$496.55	\$467.53
41	\$607.01	\$595.98	\$567.41	\$535.63	\$505.88	\$476.31
42	\$617.73	\$606.51	\$577.43	\$545.10	\$514.81	\$484.72
43	\$632.65	\$621.16	\$591.38	\$558.26	\$527.25	\$496.43
44	\$651.30	\$639.47	\$608.81	\$574.72	\$542.79	\$511.06
45	\$673.21	\$660.98	\$629.29	\$594.05	\$561.05	\$528.26
46	\$699.32	\$686.62	\$653.70	\$617.09	\$582.81	\$548.74
47	\$728.69	\$715.45	\$681.15	\$643.01	\$607.29	\$571.79
48	\$762.25	\$748.41	\$712.53	\$672.63	\$635.26	\$598.13
49	\$795.36	\$780.91	\$743.47	\$701.84	\$662.85	\$624.11
50	\$832.65	\$817.53	\$778.34	\$734.75	\$693.93	\$653.37
51	\$869.48	\$853.69	\$812.76	\$767.25	\$724.62	\$682.27
52	\$910.04	\$893.52	\$850.68	\$803.04	\$758.43	\$714.10
53	\$951.07	\$933.80	\$889.03	\$839.24	\$792.62	\$746.29
54	\$995.36	\$977.28	\$930.43	\$878.32	\$829.53	\$781.05
55	\$1,039.65	\$1,020.77	\$971.83	\$917.41	\$866.44	\$815.80
56	\$1,087.67	\$1,067.92	\$1,016.72	\$959.78	\$906.46	\$853.48
57	\$1,136.16	\$1,115.52	\$1,062.04	\$1,002.56	\$946.87	\$891.53
58	\$1,187.90	\$1,166.33	\$1,110.41	\$1,048.23	\$990.00	\$932.13
59	\$1,213.55	\$1,191.51	\$1,134.38	\$1,070.85	\$1,011.37	\$952.26
60	\$1,265.30	\$1,242.32	\$1,182.76	\$1,116.52	\$1,054.49	\$992.86
61	\$1,310.05	\$1,286.26	\$1,224.59	\$1,156.01	\$1,091.79	\$1,027.98
62	\$1,339.42	\$1,315.10	\$1,252.05	\$1,181.93	\$1,116.27	\$1,051.03
63	\$1,376.25	\$1,351.26	\$1,286.48	\$1,214.43	\$1,146.97	\$1,079.93
64+	\$1,398.63	\$1,373.22	\$1,307.40	\$1,234.17	\$1,165.62	\$1,097.49

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Silver 70 HMO 1650/55* + Child Dental Alt	Silver 70 HMO 2100/55* + Child Dental Alt Formerly 1800/55	Silver 70 HMO 2250/55* + Child Dental Formerly 2250/50	Silver 70 HMO 2600/55* + Child Dental Alt NEW Plan	Silver 70 HDHP HMO 2500/20%* + Child Dental
0-14 <sup>†</sup>	\$283.11	\$278.23	\$281.20	\$273.80	\$261.11
15 <sup>†</sup>	\$307.04	\$301.72	\$304.95	\$296.89	\$283.08
16 <sup>†</sup>	\$316.18	\$310.70	\$314.04	\$305.72	\$291.48
17 <sup>†</sup>	\$325.33	\$319.68	\$323.12	\$314.55	\$299.88
18 <sup>†</sup>	\$335.18	\$329.35	\$332.90	\$324.06	\$308.92
19	\$331.04	\$325.03	\$328.69	\$319.58	\$303.98
20	\$341.24	\$335.05	\$338.82	\$329.43	\$313.35
21	\$351.80	\$345.41	\$349.30	\$339.62	\$323.04
22	\$351.80	\$345.41	\$349.30	\$339.62	\$323.04
23	\$351.80	\$345.41	\$349.30	\$339.62	\$323.04
24	\$351.80	\$345.41	\$349.30	\$339.62	\$323.04
25	\$353.20	\$346.79	\$350.69	\$340.98	\$324.33
26	\$360.24	\$353.70	\$357.68	\$347.77	\$330.79
27	\$368.68	\$361.99	\$366.06	\$355.92	\$338.54
28	\$382.40	\$375.46	\$379.69	\$369.17	\$351.14
29	\$393.66	\$386.51	\$390.86	\$380.03	\$361.48
30	\$399.29	\$392.04	\$396.45	\$385.47	\$366.65
31	\$407.73	\$400.33	\$404.84	\$393.62	\$374.40
32	\$416.17	\$408.62	\$413.22	\$401.77	\$382.15
33	\$421.45	\$413.80	\$418.46	\$406.86	\$387.00
34	\$427.08	\$419.33	\$424.05	\$412.30	\$392.17
35	\$429.89	\$422.09	\$426.84	\$415.01	\$394.75
36	\$432.71	\$424.85	\$429.64	\$417.73	\$397.34
37	\$435.52	\$427.62	\$432.43	\$420.45	\$399.92
38	\$438.34	\$430.38	\$435.22	\$423.16	\$402.50
39	\$443.97	\$435.91	\$440.81	\$428.60	\$407.67
40	\$449.60	\$441.43	\$446.40	\$434.03	\$412.84
41	\$458.04	\$449.72	\$454.79	\$442.18	\$420.59
42	\$466.13	\$457.67	\$462.82	\$449.99	\$428.02
43	\$477.39	\$468.72	\$474.00	\$460.86	\$438.36
44	\$491.46	\$482.54	\$487.97	\$474.45	\$451.28
45	\$507.99	\$498.77	\$504.39	\$490.41	\$466.47
46	\$527.69	\$518.11	\$523.95	\$509.43	\$484.56
47	\$549.86	\$539.87	\$545.95	\$530.82	\$504.91
48	\$575.19	\$564.74	\$571.10	\$555.28	\$528.17
49	\$600.16	\$589.27	\$595.90	\$579.39	\$551.10
50	\$628.31	\$616.90	\$623.85	\$606.56	\$576.94
51	\$656.10	\$644.19	\$651.44	\$633.39	\$602.46
52	\$686.71	\$674.24	\$681.83	\$662.94	\$630.57
53	\$717.66	\$704.63	\$712.57	\$692.82	\$659.00
54	\$751.08	\$737.45	\$745.75	\$725.09	\$689.69
55	\$784.51	\$770.26	\$778.93	\$757.35	\$720.37
56	\$820.74	\$805.84	\$814.91	\$792.33	\$753.65
57	\$857.33	\$841.76	\$851.24	\$827.65	\$787.24
58	\$896.38	\$880.10	\$890.01	\$865.35	\$823.10
59	\$915.73	\$899.10	\$909.22	\$884.03	\$840.87
60	\$954.77	\$937.44	\$947.99	\$921.73	\$876.72
61	\$988.55	\$970.60	\$981.53	\$954.33	\$907.74
62	\$1,010.71	\$992.36	\$1,003.53	\$975.72	\$928.09
63	\$1,038.50	\$1,019.65	\$1,031.13	\$1,002.55	\$953.61
64+	\$1,055.40	\$1,036.23	\$1,047.90	\$1,018.86	\$969.12

<sup>†</sup>HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Bronze 60 HMO 5400/60* + Child Dental Alt <b>NEW Plan</b>	Bronze 60 HMO 6300/65* + Child Dental	Bronze 60 HDHP HMO 7000/0* + Child Dental <b>Formerly 6900/0</b>
0-14 <sup>†</sup>	\$237.48	\$241.95	\$227.39
15 <sup>†</sup>	\$257.34	\$262.21	\$246.36
16 <sup>†</sup>	\$264.94	\$269.96	\$253.61
17 <sup>†</sup>	\$272.53	\$277.71	\$260.86
18 <sup>†</sup>	\$280.71	\$286.05	\$268.67
19	\$274.90	\$280.40	\$262.49
20	\$283.38	\$289.04	\$270.58
21	\$292.14	\$297.98	\$278.95
22	\$292.14	\$297.98	\$278.95
23	\$292.14	\$297.98	\$278.95
24	\$292.14	\$297.98	\$278.95
25	\$293.31	\$299.18	\$280.07
26	\$299.15	\$305.14	\$285.65
27	\$306.16	\$312.29	\$292.34
28	\$317.56	\$323.91	\$303.22
29	\$326.91	\$333.44	\$312.15
30	\$331.58	\$338.21	\$316.61
31	\$338.59	\$345.36	\$323.30
32	\$345.60	\$352.51	\$330.00
33	\$349.98	\$356.98	\$334.18
34	\$354.66	\$361.75	\$338.65
35	\$357.00	\$364.14	\$340.88
36	\$359.33	\$366.52	\$343.11
37	\$361.67	\$368.90	\$345.34
38	\$364.01	\$371.29	\$347.57
39	\$368.68	\$376.06	\$352.04
40	\$373.36	\$380.82	\$356.50
41	\$380.37	\$387.97	\$363.19
42	\$387.09	\$394.83	\$369.61
43	\$396.43	\$404.36	\$378.54
44	\$408.12	\$416.28	\$389.70
45	\$421.85	\$430.29	\$402.81
46	\$438.21	\$446.98	\$418.43
47	\$456.62	\$465.75	\$436.00
48	\$477.65	\$487.20	\$456.09
49	\$498.39	\$508.36	\$475.89
50	\$521.76	\$532.20	\$498.21
51	\$544.84	\$555.74	\$520.24
52	\$570.26	\$581.66	\$544.51
53	\$595.97	\$607.89	\$569.06
54	\$623.72	\$636.19	\$595.56
55	\$651.47	\$664.50	\$622.06
56	\$681.56	\$695.20	\$650.79
57	\$711.95	\$726.19	\$679.80
58	\$744.37	\$759.26	\$710.77
59	\$760.44	\$775.65	\$726.11
60	\$792.87	\$808.73	\$757.07
61	\$820.91	\$837.33	\$783.85
62	\$839.32	\$856.11	\$801.43
63	\$862.40	\$879.65	\$823.46
64+	\$876.42	\$893.94	\$836.85

<sup>†</sup>HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/20* + Child Dental Formerly 0/15	Gold 80 HMO 0/30* + Child Dental Alt	Gold 80 HMO 250/35* + Child Dental Formerly 250/25 Replaced 500/30	Gold 80 HMO 1000/40* + Child Dental Alt NEW Plan	Gold 80 HRA HMO 2250/35 + Child Dental
0-14†	\$363.85	\$357.49	\$341.03	\$322.71	\$305.56	\$288.52
15†	\$394.95	\$388.03	\$370.10	\$350.15	\$331.48	\$312.92
16†	\$406.84	\$399.70	\$381.21	\$360.64	\$341.39	\$322.25
17†	\$418.73	\$411.38	\$392.33	\$371.14	\$351.30	\$331.58
18†	\$431.53	\$423.95	\$404.30	\$382.44	\$361.97	\$341.63
19	\$430.35	\$422.53	\$402.28	\$379.75	\$358.65	\$337.69
20	\$443.61	\$435.55	\$414.67	\$391.45	\$369.70	\$348.10
21	\$457.33	\$449.02	\$427.50	\$403.56	\$381.14	\$358.86
22	\$457.33	\$449.02	\$427.50	\$403.56	\$381.14	\$358.86
23	\$457.33	\$449.02	\$427.50	\$403.56	\$381.14	\$358.86
24	\$457.33	\$449.02	\$427.50	\$403.56	\$381.14	\$358.86
25	\$459.16	\$450.82	\$429.21	\$405.17	\$382.66	\$360.30
26	\$468.31	\$459.80	\$437.76	\$413.24	\$390.28	\$367.47
27	\$479.28	\$470.58	\$448.02	\$422.93	\$399.43	\$376.09
28	\$497.12	\$488.09	\$464.69	\$438.67	\$414.30	\$390.08
29	\$511.75	\$502.46	\$478.37	\$451.58	\$426.49	\$401.57
30	\$519.07	\$509.64	\$485.21	\$458.04	\$432.59	\$407.31
31	\$530.05	\$520.42	\$495.47	\$467.72	\$441.74	\$415.92
32	\$541.02	\$531.20	\$505.73	\$477.41	\$450.89	\$424.53
33	\$547.88	\$537.93	\$512.14	\$483.46	\$456.60	\$429.92
34	\$555.20	\$545.12	\$518.98	\$489.92	\$462.70	\$435.66
35	\$558.86	\$548.71	\$522.40	\$493.15	\$465.75	\$438.53
36	\$562.52	\$552.30	\$525.82	\$496.37	\$468.80	\$441.40
37	\$566.17	\$555.89	\$529.24	\$499.60	\$471.85	\$444.27
38	\$569.83	\$559.48	\$532.66	\$502.83	\$474.90	\$447.14
39	\$577.15	\$566.67	\$539.50	\$509.29	\$481.00	\$452.88
40	\$584.47	\$573.85	\$546.34	\$515.75	\$487.09	\$458.63
41	\$595.44	\$584.63	\$556.60	\$525.43	\$496.24	\$467.24
42	\$605.96	\$594.96	\$566.43	\$534.71	\$505.01	\$475.49
43	\$620.60	\$609.33	\$580.11	\$547.63	\$517.20	\$486.98
44	\$638.89	\$627.29	\$597.21	\$563.77	\$532.45	\$501.33
45	\$660.39	\$648.39	\$617.31	\$582.74	\$550.36	\$518.20
46	\$686.00	\$673.54	\$641.25	\$605.33	\$571.71	\$538.29
47	\$714.81	\$701.83	\$668.18	\$630.76	\$595.72	\$560.90
48	\$747.74	\$734.16	\$698.96	\$659.81	\$623.16	\$586.74
49	\$780.21	\$766.04	\$729.31	\$688.47	\$650.22	\$612.22
50	\$816.79	\$801.96	\$763.51	\$720.75	\$680.71	\$640.93
51	\$852.92	\$837.43	\$797.28	\$752.63	\$710.82	\$669.28
52	\$892.71	\$876.50	\$834.47	\$787.74	\$743.98	\$700.50
53	\$932.95	\$916.01	\$872.09	\$823.26	\$777.52	\$732.08
54	\$976.40	\$958.67	\$912.71	\$861.59	\$813.73	\$766.17
55	\$1,019.85	\$1,001.33	\$953.32	\$899.93	\$849.94	\$800.26
56	\$1,066.95	\$1,047.57	\$997.35	\$941.50	\$889.19	\$837.22
57	\$1,114.51	\$1,094.27	\$1,041.81	\$983.47	\$928.83	\$874.55
58	\$1,165.28	\$1,144.11	\$1,089.26	\$1,028.26	\$971.14	\$914.38
59	\$1,190.43	\$1,168.81	\$1,112.78	\$1,050.46	\$992.10	\$934.12
60	\$1,241.19	\$1,218.65	\$1,160.23	\$1,095.25	\$1,034.41	\$973.95
61	\$1,285.10	\$1,261.76	\$1,201.27	\$1,133.99	\$1,071.00	\$1,008.40
62	\$1,313.91	\$1,290.05	\$1,228.20	\$1,159.42	\$1,095.01	\$1,031.01
63	\$1,350.04	\$1,325.52	\$1,261.97	\$1,191.30	\$1,125.12	\$1,059.36
64+	\$1,371.99	\$1,347.06	\$1,282.50	\$1,210.68	\$1,143.42	\$1,076.58

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Silver 70 HMO 1650/55* + Child Dental Alt	Silver 70 HMO 2100/55* + Child Dental Alt Formerly 1800/55	Silver 70 HMO 2250/55* + Child Dental Formerly 2250/50	Silver 70 HMO 2600/55* + Child Dental Alt NEW Plan	Silver 70 HDHP HMO 2500/20%* + Child Dental
0-14 <sup>†</sup>	\$277.99	\$273.19	\$276.11	\$268.85	\$256.41
15 <sup>†</sup>	\$301.45	\$296.23	\$299.41	\$291.50	\$277.95
16 <sup>†</sup>	\$310.43	\$305.04	\$308.32	\$300.17	\$286.19
17 <sup>†</sup>	\$319.40	\$313.85	\$317.23	\$308.83	\$294.43
18 <sup>†</sup>	\$329.06	\$323.34	\$326.82	\$318.16	\$303.31
19	\$324.73	\$318.84	\$322.43	\$313.49	\$298.19
20	\$334.74	\$328.66	\$332.36	\$323.16	\$307.38
21	\$345.10	\$338.83	\$342.64	\$333.15	\$316.88
22	\$345.10	\$338.83	\$342.64	\$333.15	\$316.88
23	\$345.10	\$338.83	\$342.64	\$333.15	\$316.88
24	\$345.10	\$338.83	\$342.64	\$333.15	\$316.88
25	\$346.48	\$340.18	\$344.01	\$334.48	\$318.15
26	\$353.38	\$346.96	\$350.87	\$341.15	\$324.49
27	\$361.66	\$355.09	\$359.09	\$349.14	\$332.09
28	\$375.12	\$368.31	\$372.45	\$362.13	\$344.45
29	\$386.16	\$379.15	\$383.42	\$372.79	\$354.59
30	\$391.68	\$384.57	\$388.90	\$378.12	\$359.66
31	\$399.97	\$392.70	\$397.12	\$386.12	\$367.27
32	\$408.25	\$400.83	\$405.35	\$394.12	\$374.87
33	\$413.42	\$405.92	\$410.49	\$399.11	\$379.63
34	\$418.95	\$411.34	\$415.97	\$404.44	\$384.70
35	\$421.71	\$414.05	\$418.71	\$407.11	\$387.23
36	\$424.47	\$416.76	\$421.45	\$409.77	\$389.77
37	\$427.23	\$419.47	\$424.19	\$412.44	\$392.30
38	\$429.99	\$422.18	\$426.93	\$415.10	\$394.84
39	\$435.51	\$427.60	\$432.42	\$420.43	\$399.91
40	\$441.03	\$433.02	\$437.90	\$425.77	\$404.98
41	\$449.31	\$441.16	\$446.12	\$433.76	\$412.58
42	\$457.25	\$448.95	\$454.00	\$441.42	\$419.87
43	\$468.29	\$459.79	\$464.97	\$452.08	\$430.01
44	\$482.10	\$473.34	\$478.67	\$465.41	\$442.69
45	\$498.32	\$489.27	\$494.78	\$481.07	\$457.58
46	\$517.64	\$508.24	\$513.97	\$499.72	\$475.33
47	\$539.38	\$529.59	\$535.55	\$520.71	\$495.29
48	\$564.23	\$553.99	\$560.22	\$544.70	\$518.11
49	\$588.73	\$578.04	\$584.55	\$568.35	\$540.60
50	\$616.34	\$605.15	\$611.96	\$595.01	\$565.96
51	\$643.60	\$631.92	\$639.03	\$621.32	\$590.99
52	\$673.63	\$661.39	\$668.84	\$650.31	\$618.56
53	\$703.99	\$691.21	\$698.99	\$679.63	\$646.44
54	\$736.78	\$723.40	\$731.55	\$711.27	\$676.55
55	\$769.56	\$755.59	\$764.10	\$742.92	\$706.65
56	\$805.11	\$790.49	\$799.39	\$777.24	\$739.29
57	\$841.00	\$825.73	\$835.02	\$811.89	\$772.25
58	\$879.30	\$863.34	\$873.06	\$848.87	\$807.42
59	\$898.28	\$881.97	\$891.90	\$867.19	\$824.85
60	\$936.59	\$919.58	\$929.94	\$904.17	\$860.02
61	\$969.72	\$952.11	\$962.83	\$936.15	\$890.45
62	\$991.46	\$973.46	\$984.42	\$957.14	\$910.41
63	\$1,018.72	\$1,000.22	\$1,011.49	\$983.46	\$935.44
64+	\$1,035.30	\$1,016.49	\$1,027.92	\$999.45	\$950.64

<sup>†</sup>HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.



A SEPERATE \$20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

## Small Business medical plan rates

Age on 2021 effective date	Bronze 60 HMO 5400/60* + Child Dental Alt <b>NEW Plan</b>	Bronze 60 HMO 6300/65* + Child Dental	Bronze 60 HDHP HMO 7000/0* + Child Dental <b>Formerly 6900/0</b>
0-14 <sup>†</sup>	\$233.22	\$237.61	\$223.32
15 <sup>†</sup>	\$252.71	\$257.48	\$241.93
16 <sup>†</sup>	\$260.16	\$265.08	\$249.05
17 <sup>†</sup>	\$267.61	\$272.68	\$256.16
18 <sup>†</sup>	\$275.63	\$280.87	\$263.82
19	\$269.67	\$275.06	\$257.49
20	\$277.98	\$283.54	\$265.43
21	\$286.58	\$292.31	\$273.64
22	\$286.58	\$292.31	\$273.64
23	\$286.58	\$292.31	\$273.64
24	\$286.58	\$292.31	\$273.64
25	\$287.72	\$293.48	\$274.73
26	\$293.45	\$299.32	\$280.21
27	\$300.33	\$306.34	\$286.77
28	\$311.51	\$317.74	\$297.44
29	\$320.68	\$327.09	\$306.20
30	\$325.26	\$331.77	\$310.58
31	\$332.14	\$338.78	\$317.15
32	\$339.02	\$345.80	\$323.71
33	\$343.32	\$350.18	\$327.82
34	\$347.90	\$354.86	\$332.20
35	\$350.20	\$357.20	\$334.39
36	\$352.49	\$359.54	\$336.57
37	\$354.78	\$361.88	\$338.76
38	\$357.07	\$364.22	\$340.95
39	\$361.66	\$368.89	\$345.33
40	\$366.24	\$373.57	\$349.71
41	\$373.12	\$380.58	\$356.28
42	\$379.71	\$387.31	\$362.57
43	\$388.88	\$396.66	\$371.33
44	\$400.35	\$408.35	\$382.27
45	\$413.82	\$422.09	\$395.13
46	\$429.86	\$438.46	\$410.46
47	\$447.92	\$456.88	\$427.70
48	\$468.55	\$477.92	\$447.40
49	\$488.90	\$498.68	\$466.83
50	\$511.82	\$522.06	\$488.72
51	\$534.46	\$545.15	\$510.34
52	\$559.40	\$570.58	\$534.14
53	\$584.61	\$596.31	\$558.22
54	\$611.84	\$624.08	\$584.22
55	\$639.06	\$651.85	\$610.21
56	\$668.58	\$681.95	\$638.40
57	\$698.39	\$712.35	\$666.86
58	\$730.20	\$744.80	\$697.23
59	\$745.96	\$760.88	\$712.28
60	\$777.77	\$793.32	\$742.65
61	\$805.28	\$821.38	\$768.92
62	\$823.33	\$839.80	\$786.16
63	\$845.97	\$862.89	\$807.78
64+	\$859.74	\$876.93	\$820.92

<sup>†</sup>HMO 0-14, 15, 16, 17 and 18 age rates include the cost of \$13.99 for Child Dental coverage.

# Delta Dental Plan Options through the Associations

Effective Date: December 01, 2021 - November 30, 2022

Insurance Carrier	DeltaCare USA	Delta Dental
Plan Name	Plan 11B	Fee For Service
Plan Type	HMO	DPO
Provider Network	DeltaCare USA Network ONLY	PPO or Premier Network
Calendar Year Maximum	Unlimited	\$1,000
Deductible:	None	Single \$50/Family \$ 150
Waived for Preventive	Not Applicable	Yes
Diagnostic		<b>"Delta Pays" (A)</b>
Office Visit	\$20 copay	\$26.00
Periodic Oral Evaluation	No Charge	\$17.00
Comprehensive Oral Evaluation	No Charge	\$22.00
Bitewing X-rays	No Charge	\$12.00 - \$26.00
Other X-rays	No Charge	\$5.00 - \$50.00
Preventive		<b>"Delta Pays" (A)</b>
Cleanings Adult	No Charge	\$40.00
Child through Age 13	Additional Cleanings: \$45.00 No Charge Additional Cleanings: \$35.00	Not Applicable \$32.00 Not Applicable
Restorative	No Charge - \$240 copay	<b>"Delta Pays" (A)</b> \$53.00 - \$148.00
Oral Surgery	No Charge - \$110 copay	\$26.00 - \$175.00
Endodontics (Root Canals)	No Charge - \$250 copay	\$50.00 - \$402.00
Periodontics (Deep Cleaning)	\$80 copay - \$280 copay	\$39.00 - \$448.00
Waiting Period	None	<b>"Delta Pays" (A)</b> None
Crowns	\$55 copay - \$240 copay	\$343.00 - \$391.00
Prosthodontics, Removable	\$20 copay - \$210 copay	\$255.00 - \$676.00
Prosthodontics, Fixed	\$40 copay - \$240 copay	\$191.00 - \$605.00
Orthodontia		
Pretreatment/Post Treatment	\$200 copay / \$70 copay	
Limited Treatment Child to 19	\$950 copay	<b>NOT COVERED</b>
Limited Treatment 19 to Adult	\$1,150 copay	
Comprehensive Treatment Child to 19	\$1,700 copay	
Comprehensive Treatment 19 to Adult	\$1,900 copay	
<b>Monthly Premium Rate</b>		
Subscriber Only	\$38.80	\$55.84
Subscriber+1	\$58.47	\$98.45
Subscriber+2 or more	\$82.42	\$129.24

(A) For each procedure, you are responsible for the portion of the dentist's fee that is more than the amount listed in the "Delta Dental Pays" column.

# Vision Plan through Associations

Effective December 01, 2021 - November 30, 2022

MEDICAL EYE SERVICES (MES)		
12/12/24 PLAN		
Vision Benefits	In-Network	Out-of-Network
Deductible		
Exams	\$10 deductible	\$10 deductible
Material	\$25 deductible	\$25 deductible
Exam	1 comprehensive exam in any 12 consecutive months	
Comprehensive Exam	No Charge	Up to \$40
Lenses (per pair)	1 pair of standard lenses in any 12 consecutive months	
Frames	1 standard frame in any 24 consecutive months	
	Up to retail cost of \$130	Up to \$75
Contact Lenses * Contact lenses are in lieu of lenses and frames	1 pair of standard lenses in any 12 consecutive months	
Cosmetic/Convenience	Up to \$130	Up to \$130
Medically Necessary	No Charge	Up to \$250

Monthly Premium Rates			
	Subscriber	Subscriber & Spouse OR Subscriber & (1) Child	Subscriber & Family
Monthly Rates	\$8.59	\$15.66	\$21.57

## Other Services:

Life Insurance Options, Long Term Disability Plans, Medicare Supplements, Prescription Drug Plans