

# 2024-2025 Member Benefit Program



## Association of Commercial Real Estate



## Broker Contact



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*American River Benefit Administrators*

For detailed plan information, forms and directories please visit <https://www.arbadmin.com/association-plans.html>

# Dental





# Delta Dental Plan Options through the Associations

Effective Date: December 01, 2024 - November 30, 2026

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		"Delta Pays" (A)
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		"Delta Pays" (A)
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	"Delta Pays" (A) \$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	"Delta Pays" (A) 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	NOT COVERED
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.



# Cypress Dental Benefits

## Dental Options through the Associations

Effective Date: December 01, 2024 - November 30, 2025

Plan Name	Cypress DHMO CA7740	\$1,500 PPO (MAC)	\$1,500 PPO (UCR)
<b>Plan Type</b>	DHMO	DPO (MAC)	DPO (UCR)
<b>Provider Network</b>	Administered by MIB	CEN / PPO / Out-of-Network	CEN / PPO / Out-of-Network
<b>Calendar Year Maximum</b>	Unlimited	\$1,500 / \$1,500 / \$1,500	\$1,500 / \$1,500 / \$1,500
<b>Deductible:</b>	None	\$25 / \$50 / \$50 Max 3 per family	\$25 / \$50 / \$50 Max 3 per family
<b>Waived for Preventive</b>	Not Applicable	Yes / Yes / Yes	Yes / Yes / Yes
<b><u>Preventive Services</u></b>	No waiting period \$0 copay	No waiting period	No waiting period
Office Visit	\$0 copay		
Comprehensive Oral Evaluation	D0150 - \$0 copay		
Intraoral, periapical, add'l radiographic image	D0230 - \$0 copay	100% / 100% / 100% (MAC)	100% / 100% / 100% (UCR)
Bitewing X-rays	D0274 - \$0 copay		
Other X-rays (Panoramic images)	D0330 - \$0 copay		
Cleanings	D1110 - \$0 copay		
<b><u>Basic Services</u></b>	No waiting period	No waiting period	No waiting period
Fillings (Amalgam, 2 surfaces)	D2150 - \$10 copay		
Fillings (composite, 2 surfaces, anterior)	D2331 - \$10 copay		
Fillings (Composite, 2 surfaces, posterior)	D2392 - \$65 copay	90% / 80% / 80% (MAC)	90% / 80% / 80% (UCR)
Root canal, molar (excluding final restoration)	D3330 - \$125 copay		
Periodontal scaling/planning	D4341 - \$25 copay		
<b><u>Major Services</u></b>	No waiting period	No waiting period (1)	No waiting period (1)
Crown, porcelain fused to high noble metal	D2750 - \$145 copay		
Crown, resin with high noble metal	D6720 - \$145 copay	60% / 50% / 50% (MAC)	60% / 50% / 50% (UCR)
Complete denture, maxillary	D5110 - \$200 copay		
Surgical removal of erupted tooth	D7210 - \$25 copay		
<b><u>Orthodontia</u></b>	No waiting period	Not Covered	Not Covered
Comprehensive treatment of children	D8080 - \$1,600 copay		
Comprehensive treatment of adults	D8090 - \$2,100 copay		
Monthly Premium Rate	Cypress DHMO CA7740	\$1,500 PPO (MAC)	\$1,500 PPO (UCR)
Subscriber Only	\$28.93	\$49.21	\$59.08
Subscriber+Spouse	\$41.86	\$90.40	\$106.96
Subscriber+Child(ren)	\$39.80	\$89.28	\$128.04
Subscriber+Family	\$56.91	\$141.56	\$164.15

CEN: Cypress Exclusive Network is not available in all areas. Cypress does not guarantee that all services can be rendered by a CEN provider

MAC: Benefits are paid using fee schedules, less coinsurance and deductibles

UCR: Benefits are paid at the 90th percentile on the Usual, Customary, and Reasonable (UCR), less coinsurance and deductible

(1) No waiting period for timely applicants

# Vision





## Association Vision Plan

Effective Date: December 1, 2024 - November 30, 2025



Vision Benefit	VSP Vision Care
	<b>In-Network</b>
Copay Exams	\$10.00
Copay Materials	\$25.00
Exam	One Every 12 Months
Lenses (per pair)	One Pair Every 12 Months
Frames	Once Every 12 Months
Frame Retail Allowance	\$150.00
Contact Lenses	Once Every 12 Months
Contact lenses are in lieu of frames	Up to \$150.00
Rates	VSP Vision Care
Employee Only	\$8.40
Employee & Spouse	\$15.84
Employee & Child(ren)	\$16.85
Family	\$26.33
Administered through Cypress Dental	

# Medical





# Comparing Medical Plans

Medical Plan Options are commonly referred to as “Metal Plans” representing different tiers of coverage and affordability.

## Platinum

- Low deductible
- Low Copays
- Low coinsurance
- Higher premium costs

## Gold

- Low/Moderate deductible
- Moderate Copays
- Low/Moderate coinsurance
- High/Moderate premium costs

## Silver

- Moderate/High deductible
- Moderate/High Copays & Coinsurance
- Low / Moderate premium costs

## Bronze

- High Deductible
- Must meet deductible before plan pays
- Low premium costs

*Some high deductible health plans (HDHP) are HSA compatible offering a tax advantage*

# Choosing a Medical Plan



## Deductible

The amount of healthcare cost you will have to pay before the plan starts paying.



## Coinsurance

After the deductible is met, you and the plan share in the cost of services.  
(Example: if the plan pays 80% you will pay 20%)



## Copay

A set amount defined by the plan that you will pay when you receive care.  
(Example: You pay a set dollar amount when you visit your doctor)

## Out of Pocket Maximum

Protects you from large medical bills once your out of pocket reaches this amount. The plan will pay 100% once eligible expenses exceed that amount.

## In and Out of Network

In Network services will always be the lowest cost option. Check your plan for non network coverage. It may be less coverage or no coverage except in an emergency.



## Balance Billing

In-network providers are not allowed to bill more than the plan allows, out of network providers can charge the excess of the plan allowance to “balance” the charges.

**TIPS:** Check the Network to ensure your doctor or hospital is covered.  
Consider premium cost, deductibles and copays that may affect your true out of pocket.



# Platinum Plans

Plan Benefit Summary	Platinum 90 HMO 0/10 + Child Dental Alt	Platinum 90 HMO 0/20 + Child Dental
Annual Medical Deductible	\$0	\$0
Drug Benefits Deductible		
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: \$3,000 Family: \$6,000	Individual: \$4,500 Family: \$9,000
Primary Care Visit to Treat an Injury or Illness	\$10 copay	\$20 copay
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$10 copay	\$20 copay
Specialist Visit	\$20 copay	\$30 copay
X-rays and Diagnostic Imaging	\$40 copay	\$30 copay
Laboratory Outpatient and Professional Services	\$20 copay	\$20 copay
Preventive Care/Screening/Immunization	No Charge	No Charge
Urgent Care Centers or Facilities	\$10 copay	\$20 copay
Emergency Room Services	\$200 copay	\$150 copay
Inpatient Hospital Services (e.g., Hospital Stay)	\$500 copay per admission	\$250 copay per day up to 5 days
Generic Drugs	\$5 copay	\$5 copay
Preferred Brand Drugs	\$15 copay	\$20 copay
Non-Preferred Brand Drugs	\$15 copay	\$20 copay
Specialty Drugs	10% coinsurance	10% coinsurance

# Gold Plans

Plan Benefit Summary	Gold 80 HMO 0/35 + Child Dental Alt	Gold 80 HMO 250/35 + Child Dental	Gold 80 HMO 1000/40 + Child Dental Alt
Annual Medical Deductible	\$0	Individual: \$250 Family: \$500	Individual: \$1,000 Family: \$2,000
Drug Benefits Deductible			Individual: \$250 Family: \$500
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: \$7,700 Family: \$15,400	Individual: \$7,800 Family: \$15,600	Individual: \$7,800 Family: \$15,600
Primary Care Visit to Treat an Injury or Illness	\$35 copay	\$35 copay	\$40 copay
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$35 copay	\$35 copay	\$40 copay
Specialist Visit	\$60 copay	\$55 copay	\$60 copay
X-rays and Diagnostic Imaging	\$40 copay	\$55 copay	\$60 copay
Laboratory Outpatient and Professional Services	\$30 copay	\$35 copay	\$30 copay
Preventive Care/Screening/Immunization	No Charge	No Charge	No Charge
Urgent Care Centers or Facilities	\$35 copay	\$35 copay	\$40 copay
Emergency Room Services	\$350 copay	\$250 copay after deductible	\$350 copay
Inpatient Hospital Services (e.g., Hospital Stay)	\$600 copay per day up to 5 days	\$600 copay per day after deductible up to 5 days	\$600 copay per day after deductible up to 5 days
Generic Drugs	\$15 copay	\$15 copay	\$20 copay
Preferred Brand Drugs	\$50 copay	\$40 copay	\$50 copay after deductible
Non-Preferred Brand Drugs	\$50 copay	\$40 copay	\$50 copay after deductible
Specialty Drugs	20% coinsurance	20% coinsurance	20% coinsurance after deductible



# Silver Plans

Plan Benefit Summary	Silver 70 HMO 1900/65 + Child Dental Alt	Silver 70 HMO 2500/55 + Child Dental	Silver 70 HDHP HMO 2850/25% + Child Dental
Annual Medical Deductible	Individual: \$1,900 Family: \$3,800	Individual: \$2,500 Family: \$5,000	Self Only: \$2,850 Individual: \$3,200
Drug Benefits Deductible		Individual: \$300 Family: \$600	Family: \$5,700
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: \$8,750 Family: \$17,500	Individual: \$8,750 Family: \$17,500	Individual: \$7,500 Family: \$15,000
Primary Care Visit to Treat an Injury or Illness	\$65 copay	\$55 copay	25% coinsurance after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$65 copay	\$55 copay	25% coinsurance after deductible
Specialist Visit	\$100 copay	\$90 copay	25% coinsurance after deductible
X-rays and Diagnostic Imaging	\$75 copay	\$90 copay	25% coinsurance after deductible
Laboratory Outpatient and Professional Services	\$30 copay	\$55 copay	25% coinsurance after deductible
Preventive Care/Screening/Immunization	No Charge	No Charge	No Charge
Urgent Care Centers or Facilities	\$65 copay	\$55 copay	25% coinsurance after deductible
Emergency Room Services	45% coinsurance after deductible	35% coinsurance after deductible	25% coinsurance after deductible
Inpatient Hospital Services (e.g., Hospital Stay)	45% coinsurance after deductible	35% coinsurance after deductible	25% coinsurance after deductible
Generic Drugs	\$20 copay	\$19 copay	25% coinsurance after deductible
Preferred Brand Drugs	\$100 copay	\$85 copay after deductible	25% coinsurance after deductible
Non-Preferred Brand Drugs	\$100 copay	\$85 copay after deductible	25% coinsurance after deductible
Specialty Drugs	20% coinsurance after deductible	30% coinsurance after deductible	25% coinsurance after deductible

# Bronze Plans

Plan Benefit Summary	Bronze 60 HMO 6300/60 + Child Dental	Bronze 60 HDHP HMO 7050/0 + Child Dental
Annual Medical Deductible	Individual: \$6,300 Family: \$12,600	Individual: \$7,050 Family: \$14,100
Drug Benefits Deductible	Individual: \$500 Family: \$1,000	
Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: \$8,600 Family: \$17,200	Individual: \$7,050 Family: \$14,100
Primary Care Visit to Treat an Injury or Illness	\$60 copay	No Charge after deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$60 copay	No Charge after deductible
Specialist Visit	\$95 copay	No Charge after deductible
X-rays and Diagnostic Imaging	40% coinsurance after deductible	No Charge after deductible
Laboratory Outpatient and Professional Services	\$40 copay	No Charge after deductible
Preventive Care/Screening/Immunization	No Charge	No Charge
Urgent Care Centers or Facilities	\$65 copay	No Charge after deductible
Emergency Room Services	40% coinsurance after deductible	No Charge after deductible
Inpatient Hospital Services (e.g., Hospital Stay)	40% coinsurance after deductible	No Charge after deductible
Generic Drugs	\$17 copay after deductible	No Charge after deductible
Preferred Brand Drugs	40% coinsurance after deductible	No Charge after deductible
Non-Preferred Brand Drugs	40% coinsurance after deductible	No Charge after deductible
Specialty Drugs	40% coinsurance after deductible	No Charge after deductible

**WHA**

# Platinum Plans

Annual Deductible	Gateway 30 Platinum 90 HMO	Gateway 70 Platinum 90 HMO
Medical Deductible	\$0	\$0
Drug Benefits Deductible		
Annual Out of Pocket Max for Med and Drug EHB Benefits (Total)	Individual: \$4,000 Family: \$8,000	Individual: \$4,000 Family: \$8,000
Primary Care Visit to Treat an Injury or Illness	\$30 Copay	\$20 Copay
Specialist Visit	\$30 Copay	\$20 Copay
X-rays and Diagnostic Imaging	No Charge	No Charge
Laboratory Outpatient and Professional Services	No Charge	No Charge
Preventive Care/Screening/Immunization	No Charge	No Charge
Urgent Care Centers or Facilities	\$50 Copay	\$50 Copay
Emergency Room Services	\$150 Copay (waived if admitted)	\$150 Copay (waived if admitted)
Inpatient Hospital Services (e.g., Hospital Stay)	\$300 Copay (days 1-3)	30% Coinsurance
Generic Drugs	\$5 Copay	\$5 Copay
Preferred Brand Drugs	\$30 Copay	\$30 Copay
Non-Preferred Brand Drugs	\$50 Copay	\$50 Copay
Specialty Drugs	20% up to \$250	20% up to \$250

**WHA**



# Gold Plans

Annual Deductible	Gateway 4010 Gold 80 HMO	Gateway 2600 Gold 80 HDHP HMO
Medical Deductible	Self Only: \$1,000 Individual: \$1,000 Family: \$2,000	Self Only: \$2,600 Individual with Family Coverage: \$3,200 Family: \$5,200
Drug Benefits Deductible	Self Only: \$500 Individual: \$500 Family: \$1,000	
Annual Out of Pocket Max for Med and Drug EHB Benefits (Total)	Self Only: \$7,800 Individual: \$7,800 Family: \$15,600	Self Only: \$4,800 Individual: \$4,800 Family: \$9,600
Primary Care Visit to Treat an Injury or Illness	\$40 Copay	No Charge after deductible
Specialist Visit	\$40 Copay	No Charge after deductible
X-rays and Diagnostic Imaging	\$40 Copay	No Charge after deductible
Laboratory Outpatient and Professional Services	No Charge	No Charge after deductible
Preventive Care/Screening/Immunization	No Charge	No Charge
Urgent Care Centers or Facilities	\$50 Copay	No Charge after deductible
Emergency Room Services	\$300 Copay after deductible (waived if admitted)	No Charge after deductible
Inpatient Hospital Services (e.g., Hospital Stay)	\$500 Copay after deductible (days 1-5)	No Charge after deductible
Generic Drugs	\$10 Copay	No Charge after deductible
Preferred Brand Drugs	\$50 Copay after deductible	\$40 Copay after deductible
Non-Preferred Brand Drugs	\$75 Copay after deductible	\$60 Copay after deductible
Specialty Drugs	20% up to \$250 (Coinsurance after deductible)	20% up to \$250 (Coinsurance after deductible)

**WHA**



# Silver Plan Bronze Plan

Annual Deductible	Gateway 5020 Silver 70 HMO	Gateway 7050 Bronze 60 HDHP HMO
Medical Deductible	Self Only: \$2,000 Individual: \$2,000 Family: \$4,000	Self Only: \$7,050 Individual with Family Coverage: \$7,050 Family: \$14,100
Drug Benefits Deductible	Self Only: \$500 Individual: \$500 Family: \$1,000	
Annual Out of Pocket Max for Med and Drug EHB Benefits (Total)	Self Only: \$8,750 Individual: \$8,750 Family: \$17,500	Self Only: \$7,050 Individual: \$7,050 Family: \$14,100
Primary Care Visit to Treat an Injury or Illness	\$50 Copay	No Charge after deductible
Specialist Visit	\$50 Copay	No Charge after deductible
X-rays and Diagnostic Imaging	\$80 Copay	No Charge after deductible
Laboratory Outpatient and Professional Services	\$50 Copay	No Charge after deductible
Preventive Care/Screening/Immunization	No Charge	No Charge
Urgent Care Centers or Facilities	\$50 Copay	No Charge after deductible
Emergency Room Services	30% Coinsurance after deductible (waived if admitted)	No Charge after deductible
Inpatient Hospital Services (e.g., Hospital Stay)	30% Coinsurance after deductible	No Charge after deductible
Generic Drugs	\$25 Copay	No Charge after deductible
Preferred Brand Drugs	30% up to \$250 (Coinsurance after deductible)	No Charge after deductible
Non-Preferred Brand Drugs	30% up to \$250 (Coinsurance after deductible)	No Charge after deductible
Specialty Drugs	30% up to \$250 (Coinsurance after deductible)	No Charge after deductible

# Medical Rates





Rating Area 1,3,5  
Small Business Medical Rate Plans

Effective: December 1, 2024 through November 30, 2025

Counties: Amador, Sutter, Yuba, El Dorado, Placer, Sacramento, Yolo, Contra Costa

Age	Platinum 90 HMO 0/10 + Child Dental Alt	Platinum 90 HMO 0/20 + Child Dental	Gold 80 HMO 0/35 + Child Dental Alt	Gold 80 HMO 250/35 + Child Dental	Gold 80 HMO 1000/40 + Child Dental Alt	Silver 70 HMO 1900/65 + Child Dental Alt	Silver 70 HMO 2500/55 + Child Dental	Silver 70 HDHP HMO 2850/25% + Child Dental	Bronze 60 HMO 6300/60 + Child Dental	Bronze 60 HDHP HMO 7050/0 + Child Dental
0-14	397.11	389.13	368.18	357.25	340.44	296.33	294.50	272.53	255.07	249.02
15	431.14	422.45	399.64	387.74	369.44	321.40	319.41	295.49	276.47	269.89
16	444.16	435.19	411.66	399.40	380.52	330.98	328.93	304.27	284.66	277.87
17	457.17	447.93	423.69	411.05	391.61	340.57	338.46	313.05	292.84	285.85
18	471.18	461.65	436.65	423.61	403.55	350.89	348.71	322.50	301.66	294.44
19	470.92	461.10	435.33	421.89	401.22	346.95	344.70	317.68	296.20	288.76
20	485.44	475.31	448.75	434.89	413.58	357.64	355.32	327.47	305.33	297.66
21	500.45	490.01	462.62	448.34	426.37	368.70	366.31	337.60	314.77	306.87
22	500.45	490.01	462.62	448.34	426.37	368.70	366.31	337.60	314.77	306.87
23	500.45	490.01	462.62	448.34	426.37	368.70	366.31	337.60	314.77	306.87
24	500.45	490.01	462.62	448.34	426.37	368.70	366.31	337.60	314.77	306.87
25	502.45	491.97	464.48	450.14	428.08	370.18	367.78	338.95	316.03	308.10
26	512.46	501.77	473.73	459.10	436.60	377.55	375.10	345.70	322.33	314.23
27	524.47	513.53	484.83	469.86	446.84	386.40	383.90	353.80	329.88	321.60
28	543.99	532.65	502.87	487.35	463.47	400.78	398.18	366.97	342.16	333.57
29	560.00	548.33	517.68	501.70	477.11	412.58	409.90	377.77	352.23	343.39
30	568.01	556.17	525.08	508.87	483.93	418.48	415.76	383.18	357.27	348.30
31	580.02	567.93	536.18	519.63	494.16	427.32	424.56	391.28	364.82	355.66
32	592.03	579.69	547.28	530.39	504.40	436.17	433.35	399.38	372.37	363.02
33	599.54	587.04	554.22	537.12	510.79	441.70	438.84	404.44	377.10	367.63
34	607.55	594.88	561.63	544.29	517.61	447.60	444.70	409.85	382.13	372.54
35	611.55	598.80	565.33	547.88	521.03	450.55	447.63	412.55	384.65	374.99
36	615.55	602.72	569.03	551.46	524.44	453.50	450.56	415.25	387.17	377.45
37	619.56	606.64	572.73	555.05	527.85	456.45	453.49	417.95	389.69	379.90
38	623.56	610.56	576.43	558.64	531.26	459.40	456.42	420.65	392.21	382.36
39	631.57	618.40	583.83	565.81	538.08	465.30	462.29	426.05	397.24	387.27
40	639.57	626.24	591.23	572.98	544.90	471.20	468.15	431.45	402.28	392.18
41	651.59	638.00	602.34	583.74	555.13	480.05	476.94	439.56	409.83	399.54
42	663.10	649.27	612.98	594.06	564.94	488.53	485.36	447.32	417.07	406.60
43	679.11	664.95	627.78	608.40	578.59	500.33	497.09	458.12	427.14	416.42
44	699.13	684.55	646.29	626.34	595.64	515.08	511.74	471.63	439.74	428.69
45	722.65	707.58	668.03	647.41	615.68	532.40	528.95	487.49	454.53	443.12
46	750.67	735.02	693.94	672.52	639.56	553.05	549.47	506.40	472.16	460.30
47	782.20	765.89	723.08	700.76	666.42	576.28	572.55	527.67	491.99	479.63
48	818.24	801.17	756.39	733.04	697.12	602.83	598.92	551.98	514.65	501.73
49	853.77	835.96	789.24	764.87	727.39	629.00	624.93	575.95	537.00	523.52
50	893.80	875.17	826.25	800.74	761.50	658.50	654.23	602.95	562.18	548.07
51	933.34	913.88	862.79	836.16	795.18	687.63	683.17	629.62	587.05	572.31
52	976.88	956.51	903.04	875.17	832.28	719.70	715.04	659.00	614.43	599.01
53	1,020.92	999.63	943.75	914.62	869.80	752.15	747.28	688.70	642.13	626.01
54	1,068.46	1,046.18	987.70	957.21	910.30	787.18	782.08	720.78	672.04	655.16
55	1,116.00	1,092.73	1,031.65	999.81	950.81	822.20	816.88	752.85	701.94	684.32
56	1,167.55	1,143.20	1,079.30	1,045.99	994.72	860.18	854.61	787.62	734.36	715.92
57	1,219.60	1,194.16	1,127.42	1,092.61	1,039.07	898.52	892.70	822.73	767.10	747.84
58	1,275.15	1,248.56	1,178.77	1,142.38	1,086.39	939.45	933.36	860.20	802.04	781.90
59	1,302.67	1,275.51	1,204.21	1,167.04	1,109.84	959.73	953.51	878.77	819.35	798.78
60	1,358.22	1,329.90	1,255.56	1,216.80	1,157.17	1,000.65	994.17	916.25	854.29	832.84
61	1,406.26	1,376.94	1,299.98	1,259.84	1,198.10	1,036.05	1,029.34	948.66	884.51	862.30
62	1,437.79	1,407.81	1,329.12	1,288.09	1,224.96	1,059.28	1,052.41	969.92	904.34	881.63
63	1,477.33	1,446.52	1,365.67	1,323.51	1,258.65	1,088.41	1,081.35	996.59	929.21	905.87
64+	1,501.35	1,470.03	1,387.86	1,345.02	1,279.11	1,106.10	1,098.93	1,012.80	944.31	920.61

A SEPARATE \$20 ADMINISTRATION FEE WILL BE ADDED TO CALCULATE THE SUBSCRIBER MONTHLY RATE





Rating Region 3  
Small Business Medical Rate Plans

Effective: December 1, 2024 through November 30, 2025

Sacramento ,Yolo, Parts of El Dorado, Parts of Placer

Age	GATEWAY 30 Platinum 90 HMO	GATEWAY 70 Platinum 90 HMO	Gateway 4010 Gold 80 HMO	Gateway 2600 Gold 80 HDHP HMO	Gateway 5020 Silver 70 HMO	GATEWAY 7050 Bronze 60 HDHP HMO
0 - 14	310.42	304.84	276.67	262.87	236.14	234.19
15	338.01	331.94	301.26	286.24	257.13	255.01
16	348.56	342.30	310.66	295.17	265.15	262.97
17	359.11	352.66	320.06	304.10	273.18	270.93
18	370.48	363.81	330.19	313.73	281.82	279.50
19	381.84	374.97	340.32	323.35	290.47	288.07
20	393.61	386.53	350.81	333.31	299.42	296.95
21	405.78	398.48	361.65	343.62	308.68	306.13
22	405.78	398.48	361.65	343.62	308.68	306.13
23	405.78	398.48	361.65	343.62	308.68	306.13
24	405.78	398.48	361.65	343.62	308.68	306.13
25	407.40	400.08	363.10	345.00	309.91	307.36
26	415.52	408.05	370.33	351.87	316.09	313.48
27	425.26	417.61	379.01	360.11	323.49	320.83
28	441.08	433.15	393.12	373.52	335.53	332.77
29	454.07	445.90	404.69	384.51	345.41	342.56
30	460.56	452.28	410.48	390.01	350.35	347.46
31	470.30	461.84	419.16	398.26	357.76	354.81
32	480.04	471.40	427.84	406.50	365.17	362.16
33	486.12	477.38	433.26	411.66	369.80	366.75
34	492.62	483.76	439.05	417.16	374.73	371.65
35	495.86	486.95	441.94	419.90	377.20	374.09
36	499.11	490.13	444.84	422.65	379.67	376.54
37	502.35	493.32	447.73	425.40	382.14	378.99
38	505.60	496.51	450.62	428.15	384.61	381.44
39	512.09	502.88	456.41	433.65	389.55	386.34
40	518.58	509.26	462.20	439.15	394.49	391.24
41	528.32	518.82	470.87	447.39	401.90	398.59
42	537.66	527.99	479.19	455.30	409.00	405.63
43	550.64	540.74	490.77	466.29	418.87	415.42
44	566.87	556.68	505.23	480.04	431.22	427.67
45	585.94	575.41	522.23	496.19	445.73	442.06
46	608.67	597.72	542.48	515.43	463.02	459.20
47	634.23	622.83	565.27	537.08	482.46	478.49
48	663.45	651.52	591.31	561.82	504.69	500.53
49	692.26	679.81	616.98	586.22	526.60	522.26
50	724.72	711.69	645.92	613.71	551.30	546.75
51	756.78	743.17	674.49	640.85	575.68	570.94
52	792.08	777.84	705.95	670.75	602.54	597.57
53	827.79	812.90	737.78	700.99	629.70	624.51
54	866.34	850.76	772.13	733.63	659.03	653.59
55	904.89	888.61	806.49	766.27	688.35	682.68
56	946.68	929.66	843.74	801.67	720.14	714.21
57	988.88	971.10	881.35	837.40	752.25	746.05
58	1,033.92	1,015.33	921.50	875.55	786.51	780.03
59	1,056.24	1,037.25	941.39	894.45	803.49	796.86
60	1,101.28	1,081.48	981.53	932.59	837.75	830.85
61	1,140.24	1,119.73	1,016.25	965.58	867.38	860.23
62	1,165.80	1,144.84	1,039.03	987.22	886.83	879.52
63	1,197.86	1,176.32	1,067.61	1,014.37	911.21	903.71
64+	1,217.34	1,195.45	1,084.96	1,030.86	926.03	918.40

Rating region is determined by the  
business/employer location



**USI Insurance Services, LLC.**  
**10940 White Rock Road, 2<sup>nd</sup> Floor**  
**Rancho Cordova, CA 95670**  
**(916) 883-0708**

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