

2024-2025 Member Benefit Program



Building Industry Association of the Greater Valley



Broker Contact



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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 Deductible: | Unlimited | \$1,000 |
| Waived for Preventive | None | Single \$50/Family \$ 150 |
| | 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 | Not Applicable |
| | No Charge | \$32.00 |
| | Additional Cleanings: \$35.00 | Not Applicable |
| Restorative | No Charge - \$240 copay | "Delta Pays" (A) |
| Oral Surgery | No Charge - \$110 copay | \$53.00 - \$148.00 |
| Endodontics (Root Canals) | No Charge - \$250 copay | \$26.00 - \$175.00 |
| Periodontics (Deep Cleaning) | \$80 copay - \$280 copay | \$50.00 - \$402.00 |
| | | \$39.00 - \$448.00 |
| Waiting Period | None | "Delta Pays" (A) |
| Crowns | \$55 copay - \$240 copay | None |
| Prosthodontics, Removable | \$20 copay - \$210 copay | \$343.00 - \$391.00 |
| Prosthodontics, Fixed | \$40 copay - \$240 copay | \$255.00 - \$676.00 |
| | | \$191.00 - \$605.00 |
| Orthodontia | | |
| Pretreatment/Post Treatment | \$200 copay / \$70 copay | |
| Limited Treatment Child to 19 | \$950 copay | |
| Limited Treatment 19 to Adult | \$1,150 copay | |
| Comprehensive Treatment Child to 19 | \$1,700 copay | |
| Comprehensive Treatment 19 to Adult | \$1,900 copay | |
| Monthly Premium Rate | | |
| 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) |
|---|----------------------------|------------------------------------|------------------------------------|
| Plan Type | DHMO | DPO (MAC) | DPO (UCR) |
| Provider Network | Administered by MIB | CEN / PPO / Out-of-Network | CEN / PPO / Out-of-Network |
| Calendar Year Maximum | Unlimited | \$1,500 / \$1,500 / \$1,500 | \$1,500 / \$1,500 / \$1,500 |
| Deductible: | None | \$25 / \$50 / \$50 | \$25 / \$50 / \$50 |
| Waived for Preventive | Not Applicable | Max 3 per family | Max 3 per family |
| | | Yes / Yes / Yes | Yes / Yes / Yes |
| <u>Preventive Services</u> | No waiting period | 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 | | |
| <u>Basic Services</u> | 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 | | |
| <u>Major Services</u> | 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 | | |
| <u>Orthodontia</u> | No waiting period | | |
| Comprehensive treatment of children | D8080 - \$1,600 copay | Not Covered | Not Covered |
| 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 |
|--------------------------------------|--------------------------|
| | In-Network |
| 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.

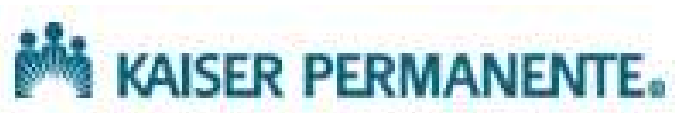


Platinum Plans

| 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 Family: \$5,700 |
| Drug Benefits Deductible | | Individual: \$300 Family: \$600 | |
| 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 |

Medical Rates





Rating Area 10
Small Business Medical Rate Plans

Effective: December 1, 2024 through November 30, 2025

Counties: Mariposa, San Joaquin, Stanislaus, Tulare

| 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 | 376.96 | 369.40 | 349.55 | 339.20 | 323.28 | 281.48 | 279.75 | 258.94 | 242.40 | 236.67 |
| 15 | 409.20 | 400.97 | 379.35 | 368.08 | 350.74 | 305.23 | 303.35 | 280.69 | 262.67 | 256.44 |
| 16 | 421.53 | 413.04 | 390.75 | 379.13 | 361.25 | 314.32 | 312.37 | 289.01 | 270.43 | 264.00 |
| 17 | 433.86 | 425.11 | 402.14 | 390.17 | 371.75 | 323.40 | 321.39 | 297.32 | 278.18 | 271.55 |
| 18 | 447.13 | 438.11 | 414.42 | 402.06 | 383.06 | 333.18 | 331.11 | 306.28 | 286.53 | 279.69 |
| 19 | 446.14 | 436.83 | 412.42 | 399.69 | 380.10 | 328.69 | 326.56 | 300.96 | 280.61 | 273.56 |
| 20 | 459.89 | 450.30 | 425.13 | 412.00 | 391.81 | 338.82 | 336.62 | 310.24 | 289.26 | 282.00 |
| 21 | 474.11 | 464.22 | 438.28 | 424.75 | 403.93 | 349.30 | 347.03 | 319.83 | 298.20 | 290.72 |
| 22 | 474.11 | 464.22 | 438.28 | 424.75 | 403.93 | 349.30 | 347.03 | 319.83 | 298.20 | 290.72 |
| 23 | 474.11 | 464.22 | 438.28 | 424.75 | 403.93 | 349.30 | 347.03 | 319.83 | 298.20 | 290.72 |
| 24 | 474.11 | 464.22 | 438.28 | 424.75 | 403.93 | 349.30 | 347.03 | 319.83 | 298.20 | 290.72 |
| 25 | 476.01 | 466.08 | 440.03 | 426.45 | 405.55 | 350.69 | 348.42 | 321.11 | 299.40 | 291.88 |
| 26 | 485.49 | 475.37 | 448.79 | 434.94 | 413.62 | 357.68 | 355.36 | 327.51 | 305.36 | 297.69 |
| 27 | 496.87 | 486.51 | 459.31 | 445.13 | 423.32 | 366.06 | 363.69 | 335.18 | 312.52 | 304.67 |
| 28 | 515.36 | 504.61 | 476.41 | 461.70 | 439.07 | 379.68 | 377.22 | 347.66 | 324.15 | 316.01 |
| 29 | 530.53 | 519.47 | 490.43 | 475.29 | 452.00 | 390.86 | 388.33 | 357.89 | 333.69 | 325.31 |
| 30 | 538.12 | 526.89 | 497.44 | 482.09 | 458.46 | 396.45 | 393.88 | 363.01 | 338.46 | 329.96 |
| 31 | 549.49 | 538.04 | 507.96 | 492.28 | 468.16 | 404.83 | 402.21 | 370.68 | 345.62 | 336.94 |
| 32 | 560.87 | 549.18 | 518.48 | 502.47 | 477.85 | 413.22 | 410.54 | 378.36 | 352.78 | 343.92 |
| 33 | 567.98 | 556.14 | 525.05 | 508.85 | 483.91 | 418.46 | 415.75 | 383.16 | 357.25 | 348.28 |
| 34 | 575.57 | 563.57 | 532.07 | 515.64 | 490.37 | 424.05 | 421.30 | 388.28 | 362.02 | 352.93 |
| 35 | 579.36 | 567.28 | 535.57 | 519.04 | 493.60 | 426.84 | 424.07 | 390.83 | 364.41 | 355.26 |
| 36 | 583.16 | 571.00 | 539.08 | 522.44 | 496.83 | 429.63 | 426.85 | 393.39 | 366.79 | 357.58 |
| 37 | 586.95 | 574.71 | 542.59 | 525.84 | 500.07 | 432.43 | 429.63 | 395.95 | 369.18 | 359.91 |
| 38 | 590.74 | 578.42 | 546.09 | 529.23 | 503.30 | 435.22 | 432.40 | 398.51 | 371.56 | 362.23 |
| 39 | 598.33 | 585.85 | 553.10 | 536.03 | 509.76 | 440.81 | 437.96 | 403.63 | 376.33 | 366.88 |
| 40 | 605.91 | 593.28 | 560.12 | 542.83 | 516.22 | 446.40 | 443.51 | 408.74 | 381.11 | 371.54 |
| 41 | 617.29 | 604.42 | 570.64 | 553.02 | 525.92 | 454.78 | 451.84 | 416.42 | 388.26 | 378.51 |
| 42 | 628.20 | 615.10 | 580.72 | 562.79 | 535.21 | 462.82 | 459.82 | 423.78 | 395.12 | 385.20 |
| 43 | 643.37 | 629.95 | 594.74 | 576.38 | 548.13 | 473.99 | 470.92 | 434.01 | 404.66 | 394.50 |
| 44 | 662.33 | 648.52 | 612.27 | 593.37 | 564.29 | 487.97 | 484.80 | 446.80 | 416.59 | 406.13 |
| 45 | 684.62 | 670.34 | 632.87 | 613.33 | 583.28 | 504.38 | 501.12 | 461.84 | 430.61 | 419.80 |
| 46 | 711.17 | 696.34 | 657.41 | 637.12 | 605.90 | 523.94 | 520.55 | 479.75 | 447.31 | 436.08 |
| 47 | 741.03 | 725.58 | 685.03 | 663.88 | 631.34 | 545.95 | 542.41 | 499.90 | 466.09 | 454.39 |
| 48 | 775.17 | 759.01 | 716.58 | 694.46 | 660.43 | 571.10 | 567.40 | 522.92 | 487.56 | 475.32 |
| 49 | 808.83 | 791.97 | 747.70 | 724.62 | 689.11 | 595.90 | 592.04 | 545.63 | 508.74 | 495.96 |
| 50 | 846.76 | 829.10 | 782.76 | 758.60 | 721.42 | 623.84 | 619.80 | 571.22 | 532.59 | 519.22 |
| 51 | 884.22 | 865.78 | 817.38 | 792.15 | 753.33 | 651.44 | 647.22 | 596.49 | 556.15 | 542.19 |
| 52 | 925.46 | 906.16 | 855.51 | 829.10 | 788.47 | 681.83 | 677.41 | 624.31 | 582.10 | 567.48 |
| 53 | 967.19 | 947.02 | 894.08 | 866.48 | 824.02 | 712.56 | 707.95 | 652.46 | 608.34 | 593.06 |
| 54 | 1,012.23 | 991.12 | 935.72 | 906.83 | 862.39 | 745.75 | 740.91 | 682.84 | 636.67 | 620.68 |
| 55 | 1,057.27 | 1,035.22 | 977.36 | 947.18 | 900.76 | 778.93 | 773.88 | 713.22 | 665.00 | 648.30 |
| 56 | 1,106.10 | 1,083.03 | 1,022.50 | 990.93 | 942.37 | 814.91 | 809.63 | 746.17 | 695.71 | 678.24 |
| 57 | 1,155.41 | 1,131.31 | 1,068.08 | 1,035.11 | 984.38 | 851.23 | 845.72 | 779.43 | 726.72 | 708.48 |
| 58 | 1,208.03 | 1,182.84 | 1,116.73 | 1,082.25 | 1,029.21 | 890.01 | 884.24 | 814.93 | 759.83 | 740.75 |
| 59 | 1,234.11 | 1,208.37 | 1,140.83 | 1,105.61 | 1,051.43 | 909.22 | 903.33 | 832.52 | 776.23 | 756.74 |
| 60 | 1,286.74 | 1,259.90 | 1,189.48 | 1,152.76 | 1,096.27 | 947.99 | 941.85 | 868.02 | 809.33 | 789.01 |
| 61 | 1,332.25 | 1,304.47 | 1,231.56 | 1,193.54 | 1,135.04 | 981.52 | 975.16 | 898.73 | 837.95 | 816.91 |
| 62 | 1,362.12 | 1,333.72 | 1,259.17 | 1,220.30 | 1,160.49 | 1,003.53 | 997.02 | 918.88 | 856.74 | 835.23 |
| 63 | 1,399.57 | 1,370.39 | 1,293.79 | 1,253.85 | 1,192.40 | 1,031.12 | 1,024.44 | 944.14 | 880.30 | 858.20 |
| 64+ | 1,422.33 | 1,392.66 | 1,314.84 | 1,274.25 | 1,211.79 | 1,047.90 | 1,041.09 | 959.49 | 894.60 | 872.16 |

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



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Please Visit:
<https://www.arbadmin.com/association-plans.html>
for detailed plan information and enrollment forms.

