MEDICAL BENEFITS AND RATES

Health Net HMO

HN ExcelCare Advantage HMO 45

Health Net EOA

HN ExcelCare EOA 30
HN ExcelCare EOA 40

Kaiser HMO

Kaiser Platinum HMO 0/20

Kaiser Deductible HMO

Kaiser Gold Ded HMO 1000/40
Kaiser Bronze Ded HMO 7050/0

PIBT Freedom

PIBT Freedom 45/1750
PIBT Freedom 45/3250
PIBT Freedom HSA 6500

ANCILLARY BENEFITS AND RATES

Dental PPO	Dental DMO
Humana Dental PPO CA	Humana DMO LS300

Vision
VSP Standard Plan

Other Benefits
TELUS Health EAP

Benefits at a Glance

Health Net HMO	
Plan Name	HN EC ADV HMO 45
Network	ExcelCare [9]
Calendar Year Deductible (Individual/Family)	Not Applicable
Out-of-pocket maximum (Individual/Family)	$5,000 / $10,000
Office Visit (PCP)	$45
Specialist Visit	$45
Outpatient Surgery/Treatment	45% per procedure
Hospital Admission	45% per admission
X-ray	No Charge
Laboratory	No Charge
Urgent Care	$45
Emergency Room	$100 per visit
Preventive Care	No Charge
Mental Health Office Visit	$45
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**
Separate calendar year deductible	$300 Brand-Name Drugs (per member)
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum
Retail prescriptions (30 day supply)	$20 / $40 / $60 / 30% ($250 max) [10]
Mail order (up to 90-day supply)	$40 / $100 / $150 / Not Available
Dental Coverage	
Pediatric dental coverage	Not Covered
Vision	
Routine exam	$45
Frames and lenses	Not Covered
Plan ID	9068

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• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply.

Benefits at a Glance

Health Net EOA	HN EC EOA 30		HN EC EOA 40	
Plan Name	HN EC EOA 30		HN EC EOA 40	
Network	ExcelCare [9]		ExcelCare [9]	
Services Rendered at	PCP	Open Access	PCP	Open Access
Calendar Year Deductible (Individual/Family)	Not Applicable		Not Applicable	
Out-of-pocket maximum (Individual/Family)	$3,500 / $7,000	$5,500 / $11,000	$5,500 / $11,000	$7,500 / $15,000
Office Visit (PCP)	$30	$50	$40	$60
Specialist Visit	$50		$60	
Outpatient Surgery/Treatment	$1,000 per procedure	Not Covered	40% per procedure	Not Covered
Hospital Admission	$1,000 per admission	Not Covered	40% per admission	Not Covered
X-ray	$15	$25	$20	$30
Laboratory	$15	$25	$20	$30
Urgent Care	$30 [45]		$40 [45]	
Emergency Room	$150 per visit [45]		$200 per visit [45]	
Preventive Care	No Charge		No Charge	
Mental Health Office Visit	$30		$40	
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**		**Generic/Brand/Non-formulary/Specialty**	
Separate calendar year deductible	$300 Brand-Name Drugs (per member)		Not Applicable	
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum		Combined with the Medical out-of-pocket maximum	
Retail prescriptions (30 day supply)	$15 / $40 / $65 / 30% ($250 max per prescription) [10]		$10 / $30 / $55 / 30% ($250 max per prescription) [10]	
Mail order (up to 90-day supply)	$30 / $100 / $162.50 / Not Available		$20 / $75 / $137.50 / Not Available	
Dental Coverage				
Pediatric dental coverage	Not Covered		Not Covered	
Vision				
Routine exam	$30	$50	$40	$60
Frames and lenses	Not Covered		Not Covered	
Plan ID	9072		9647	

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• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply. [45] When services are provided that meet the criteria for emergency care, whether within our outside the service area, the services are covered through Open Access.

Benefits at a Glance

Kaiser	
Plan Name	KP Platinum HMO 0/20
Network	Full
Calendar Year Deductible (Individual/Family)	Not Applicable
Out-of-pocket maximum (Individual/Family)	$4,500 / $9,000 [16]
Office Visit (PCP)	$20
Specialist Visit	$30
Outpatient Surgery/Treatment	$125 per procedure
Hospital Admission	$250 per day ($1,250 Maximum per admission)
X-ray	$30
Laboratory	$20
Urgent Care	$20
Emergency Room	$150 per visit
Preventive Care	No Charge [17]
Mental Health Office Visit	$20
Prescription Drugs	**Generic / Brand / Specialty**
Separate calendar year deductible	Not Applicable
Rx out-of-pocket maximum (Individual/Family)	Not Applicable
Retail prescriptions (30 day supply)	$5 / $20/ 10% [18]
Mail order (up to 90-day supply)	$10 / $40 / Not Covered
Dental Coverage	
Pediatric dental coverage	Refer to plan summary for complete details
Vision	
Routine exam	No Charge (at Kaiser Facility)
Frames and lenses	$150 allowance every 12 months (with EyeMed Network)
Plan ID	11323

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• Prescription drug benefits listed are for participating pharmacies only.

[16] Each family member becomes eligible for benefits after meeting the individual deductible. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied. [17] Preventive lab test, X-rays and immunizations are covered as part of the preventive exam. Routine adult physical exams are limited to one exam every 12 months. [18] Specialty Drugs, up to $250 maximum per prescription.

Benefits at a Glance

Kaiser		
Plan Name	KP Gold Ded HMO 1000/40	KP Bronze Ded HMO 7050/0
Network	Full	Full [35]
Calendar Year Deductible (Individual/Family)	$1,000 [2] / $2,000 [2]	$7,050 [2] / $14,100 [2]
Out-of-pocket maximum (Individual/Family)	$7,800 / $15,600 [16]	$7,050 [16] / $14,100 [16]
Office Visit (PCP)	$40 (No Deductible)	$0 (After Deductible)
Specialist Visit	$60 (No Deductible)	$0 (After Deductible)
Outpatient Surgery/Treatment	$350 (No Deductible)	$0 (After Deductible)
Hospital Admission	$600 per day (After Deductible) $3,000 Maximum per admission	$0 per admission (After Deductible)
X-ray	$60 (No Deductible)	$0 (After Deductible)
Laboratory	$30 (No Deductible)	$0 (After Deductible)
Urgent Care	$40 (No Deductible)	$0 (After Deductible)
Emergency Room	$350 per visit (No Deductible)	$0 (After Deductible)
Preventive Care	No Charge [17]	No Charge (No Deductible) [17]
Mental Health Office Visit	$40 (No Deductible)	$0 (After Deductible)
Prescription Drugs	**Generic / Brand / Specialty**	**Generic / Brand / Specialty**
Separate calendar year deductible	$250 Individual / $500 Family (Except Generic)	Subject to Plan Deductible
Rx out-of-pocket maximum (Individual/Family)	Not Applicable	Not Applicable
Retail prescriptions (30 day supply)	$20 / $50 / 20% [18]	$0 (After Deductible)
Mail order (up to 90-day supply)	$40 / $100 / Not Covered	$0 (After Deductible)
Dental Coverage		
Pediatric dental coverage	Refer to plan summary for complete details	Refer to plan summary for complete details
Vision		
Routine exam	No Charge (at Kaiser Facility)	No Charge (at Kaiser Facility)
Frames and lenses	$150 allowance every 12 months (with EyeMed Network)	$150 allowance every 12 months (with EyeMed Network)
Plan ID	11325	11743

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [16] Each family member becomes eligible for benefits after meeting the individual deductible. A family member can meet the individual annual out-of-pocket maximum before the family out-of-pocket maximum is satisfied. [17] Preventive lab test, X-rays and immunizations are covered as part of the preventive exam. Routine adult physical exams are limited to one exam every 12 months. [18] Specialty Drugs, up to $250 maximum per prescription. [35] Each family member will begin paying copays or coinsurance after meeting his or her individual deductible.

Benefits at a Glance

PIBT Freedom	PIBT freedom	PIBT freedom
Plan Name	PIBT 45/1750	PIBT 45/3250
Network	Not Applicable [37]	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$1,750 / $3,500 [2]	$3,250 / $6,500 [2]
Out-of-pocket maximum (Individual/Family)	$6,000 / $12,000	$7,500 / $15,000
Office Visit (PCP)	$45 (No Deductible) [40]	$45 (No Deductible) [40]
Specialist Visit	$50 (No Deductible) [40]	$50 (No Deductible) [40]
Outpatient Surgery/Treatment	30% per visit (After Deductible)	25% per visit (After Deductible)
Hospital Admission	$250 copay + 30% per admission (After Deductible)	$250 + 25% per admission (After Deductible)
X-ray	$40 per visit [40] (After Deductible)	$45 per visit [40] (After Deductible)
Laboratory	$40 per visit [40] (After Deductible)	$45 per visit [40] (After Deductible)
Urgent Care	$40 (No Deductible)	$45 (No Deductible)
Emergency Room	$250 copay + 30% per visit (After Deductible)	$250 copay + 25% per visit (After Deductible)
Preventive Care	No Charge (No Deductible)	No Charge (No Deductible)
Mental Health Office Visit	$45 (No Deductible)	$45 (No Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	$275 per member (Except Generic) [5]	$275 per member (Except Generic) [5]
Rx out-of-pocket maximum (Individual/Family)	Not Applicable	Not Applicable
Retail prescriptions (30-90 day supply)	$20 / $40 / $55 / Specialty Drugs Program [6] [44]	$20 / $40 / $50 / Specialty Drugs Program [6] [44]
Mail order (30-90-day supply)	$40 / $80 / $110 / Specialty Drugs Program [6] [44]	$40 / $80 / $100 / Specialty Drugs Program [6] [44]
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	No Charge [8]	No Charge [8]
Frames and lenses	Not Covered	Not Covered
Plan ID	11883	11505

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[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [5] Accrues toward the calendar year out-of-pocket maximum. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

Benefits at a Glance

PIBT Freedom	
Plan Name	PIBT HSA 6500
Network	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$6,500 / $13,000 [2]
Out-of-pocket maximum (Individual/Family)	$7,050 / $14,100
Office Visit (PCP)	30% (After Deductible) [40]
Specialist Visit	30% (After Deductible) [40]
Outpatient Surgery/Treatment	30% per visit (After Deductible)
Hospital Admission	$250 + 30% per admission (After Deductible)
X-ray	30% [40] (After Deductible)
Laboratory	30% [40] (After Deductible)
Urgent Care	30% (After Deductible)
Emergency Room	$250 + 30% per visit (After Deductible)
Preventive Care	No Charge (No Deductible)
Mental Health Office Visit	30% (After Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	Subject to the calendar year deductible
Rx out-of-pocket maximum (Individual/Family)	Not Applicable
Retail prescriptions (30-90 day supply)	$15 / $30 /$50 / Specialty Drugs Program [6] [44]
Mail order (30-90-day supply)	$30 / $60 / $100 / Specialty Drugs Program [6] [44]
Dental Coverage	
Pediatric dental coverage	Not Covered
Vision	
Routine exam	No Charge [8]
Frames and lenses	Not Covered
Plan ID	11507

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

Health Net Monthly Rates by age, effective 12/1/2024

Dependent monthly rates do not include the employee portion.

Plan Name & ID	HN EC ADV HMO 45, Plan ID #9068						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	458.91	524.07	675.28	877.78	1,091.24	1,343.87	1,346.97
+Spouse	642.48	733.70	945.40	1,228.90	1,527.76	1,881.44	1,885.78
+Child(ren)	344.18	393.04	506.45	658.32	818.41	1,007.88	1,010.21
+Spouse & Child(ren)	940.78	1,074.34	1,384.32	1,799.45	2,237.07	2,754.95	2,761.30
Plan Name & ID	**HN EC EOA 30, Plan ID #9072**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	534.98	610.51	794.24	1,032.42	1,271.27	1,566.12	1,599.94
+Spouse	748.98	854.72	1,111.94	1,445.37	1,779.78	2,192.56	2,239.93
+Child(ren)	401.22	457.88	595.66	774.28	953.41	1,174.55	1,199.92
+Spouse & Child(ren)	1,096.71	1,251.56	1,628.19	2,116.43	2,606.08	3,210.54	3,279.88
Plan Name & ID	**HN EC EOA 40, Plan ID #9647**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	464.46	537.25	681.44	895.63	1,141.99	1,382.41	1,495.35
+Spouse	650.26	752.14	954.02	1,253.88	1,598.79	1,935.37	2,093.48
+Child(ren)	348.34	402.92	511.07	671.71	856.47	1,036.78	1,121.47
+Spouse & Child(ren)	952.16	1,101.34	1,396.95	1,836.03	2,341.07	2,833.92	3,065.44

Kaiser Metal Monthly Rates by age, effective 12/1/2024

Plan	KP Platinum HMO 0/20	KP Gold Ded HMO 1000/40	KP Bronze Ded HMO 7050/0
Plan ID	11323	11325	11743
Age/Region	16	16	16
15	390.41	341.55	249.82
16	402.15	351.77	257.18
17	413.89	361.99	264.53
18	426.53	372.99	272.45
19	424.90	369.72	266.09
20	438.00	381.11	274.29
21-24	451.55	392.90	282.78
25	453.35	394.47	283.91
26	462.38	402.33	289.56
27	473.22	411.76	296.35
28	490.83	427.08	307.38
29	505.28	439.65	316.43
30	512.50	445.94	320.95
31	523.34	455.37	327.74
32	534.18	464.80	334.53
33	540.95	470.69	338.77
34	548.18	476.98	343.29
35	551.79	480.12	345.55
36	555.40	483.27	347.82
37	559.01	486.41	350.08
38	562.63	489.55	352.34
39	569.85	495.84	356.87
40	577.08	502.12	361.39
41	587.91	511.55	368.18
42	598.30	520.59	374.68
43	612.75	533.16	383.73
44	630.81	548.88	395.04
45	652.03	567.35	408.33
46	677.32	589.35	424.17
47	705.77	614.10	441.98
48	738.28	642.39	462.34
49	770.34	670.29	482.42
50	806.46	701.72	505.04
51	842.13	732.76	527.38
52	881.42	766.94	551.98
53	921.15	801.51	576.87
54	964.05	838.84	603.73
55	1,006.95	876.16	630.59
56	1,053.46	916.63	659.72
57	1,100.42	957.49	689.13
58	1,150.54	1,001.11	720.52
59	1,175.37	1,022.72	736.07
60	1,225.50	1,066.33	767.46
61	1,268.84	1,104.05	794.61
62	1,297.29	1,128.80	812.42
63	1,332.96	1,159.84	834.76
64+	1,354.65	1,178.70	848.34
Children under age 15			
1	359.70	314.84	230.59
2	719.40	629.68	461.18
3+	1,079.10	944.52	691.77

PIBT Freedom Monthly Rates by age, effective 12/1/2024

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT 45/1750				PIBT 45/3250			
Plan ID	11883				11505			
Region	16				16			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family	Employee	+Spouse	+Child(ren)	+Family
18	431.92	561.50	302.35	820.66	378.10	491.55	264.68	718.41
19	431.92	561.50	302.35	820.66	378.10	491.55	264.68	718.41
20	431.92	561.50	302.35	820.66	378.10	491.55	264.68	718.41
21	485.32	630.92	339.72	922.11	424.85	552.31	297.40	807.22
22	494.60	642.99	346.22	939.75	432.98	562.87	303.08	822.66
23	504.57	655.95	353.20	958.69	441.71	574.21	309.19	839.24
24	515.22	669.80	360.66	978.94	451.03	586.34	315.72	856.97
25	526.57	684.54	368.59	1,000.49	460.96	599.26	322.68	875.83
26	538.60	700.19	377.02	1,023.35	471.50	612.94	330.05	895.84
27	551.38	716.79	385.96	1,047.62	482.68	627.48	337.87	917.09
28	564.85	734.29	395.39	1,073.20	494.47	642.80	346.12	939.49
29	579.11	752.84	405.37	1,100.30	506.95	659.04	354.87	963.22
30	594.07	772.27	415.84	1,128.72	520.04	676.07	364.03	988.09
31	609.81	792.76	426.87	1,158.66	533.84	693.99	373.68	1,014.29
32	626.37	814.28	438.46	1,190.11	548.34	712.83	383.82	1,041.83
33	643.74	836.85	450.61	1,223.09	563.52	732.59	394.47	1,070.70
34	661.95	860.53	463.37	1,257.71	579.48	753.32	405.64	1,101.01
35	681.03	885.33	476.72	1,293.95	596.18	775.04	417.32	1,132.74
36	700.97	911.26	490.68	1,331.83	613.63	797.72	429.54	1,165.90
37	721.82	938.38	505.28	1,371.47	631.89	821.45	442.32	1,200.59
38	743.65	966.74	520.56	1,412.93	650.99	846.30	455.70	1,236.90
39	766.40	996.31	536.47	1,456.14	670.91	872.19	469.64	1,274.72
40	790.11	1,027.15	553.08	1,501.22	691.67	899.17	484.16	1,314.18
41	814.86	1,059.32	570.40	1,548.24	713.33	927.34	499.34	1,355.34
42	840.70	1,092.92	588.50	1,597.33	735.96	956.74	515.16	1,398.31
43	867.57	1,127.84	607.30	1,648.39	759.48	987.32	531.63	1,443.00
44	895.58	1,164.26	626.91	1,701.63	784.01	1,019.20	548.80	1,489.61
45	924.75	1,202.17	647.32	1,757.02	809.53	1,052.39	566.67	1,538.11
46	955.11	1,241.65	668.59	1,814.72	836.12	1,086.95	585.28	1,588.61
47	986.68	1,282.69	690.69	1,874.70	863.75	1,122.87	604.62	1,641.11
48	1,019.52	1,325.36	713.65	1,937.06	892.48	1,160.23	624.74	1,695.72
49	1,053.60	1,369.68	737.51	2,001.83	922.32	1,199.03	645.64	1,752.43
50	1,089.06	1,415.79	762.35	2,069.23	953.37	1,239.39	667.36	1,811.41
51	1,125.90	1,463.67	788.13	2,139.22	985.62	1,281.31	689.94	1,872.68
52	1,164.17	1,513.42	814.92	2,211.93	1,019.13	1,324.85	713.38	1,936.33
53	1,203.88	1,565.04	842.71	2,287.36	1,053.88	1,370.05	737.72	2,002.38
54	1,245.13	1,618.66	871.59	2,365.74	1,090.00	1,416.98	763.00	2,070.98
55	1,287.92	1,674.31	901.55	2,447.06	1,127.46	1,465.69	789.22	2,142.16
56	1,332.32	1,732.03	932.63	2,531.42	1,166.33	1,516.23	816.43	2,216.02
57	1,378.39	1,791.91	964.87	2,618.94	1,206.65	1,568.64	844.65	2,292.63
58	1,426.11	1,853.95	998.28	2,709.62	1,248.43	1,622.96	873.89	2,372.01
59	1,475.61	1,918.30	1,032.94	2,803.67	1,291.76	1,679.29	904.23	2,454.34
60	1,526.95	1,985.03	1,068.86	2,901.20	1,336.70	1,737.71	935.69	2,539.73
61	1,580.11	2,054.15	1,106.08	3,002.22	1,383.24	1,798.21	968.27	2,628.16
62	1,635.17	2,125.73	1,144.62	3,106.83	1,431.44	1,860.86	1,002.00	2,719.73
63	1,692.23	2,199.90	1,184.56	3,215.24	1,481.39	1,925.82	1,036.98	2,814.65
64+	1,768.77	2,299.41	1,238.15	3,360.67	1,548.39	2,012.92	1,083.88	2,941.96

PIBT Freedom Monthly Rates by age, effective 12/1/2024

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT HSA 6500			
Plan ID	11507			
Region	16			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family
18	301.83	392.38	211.28	573.48
19	301.83	392.38	211.28	573.48
20	301.83	392.38	211.28	573.48
21	339.15	440.88	237.40	644.37
22	345.63	449.32	241.94	656.70
23	352.60	458.37	246.82	669.93
24	360.04	468.06	252.04	684.09
25	367.97	478.36	257.58	699.14
26	376.38	489.30	263.47	715.12
27	385.31	500.90	269.72	732.09
28	394.72	513.13	276.30	749.96
29	404.68	526.09	283.28	768.91
30	415.14	539.67	290.59	788.75
31	426.14	553.99	298.31	809.68
32	437.71	569.03	306.41	831.66
33	449.84	584.80	314.89	854.71
34	462.57	601.35	323.81	878.90
35	475.90	618.68	333.15	904.23
36	489.84	636.79	342.89	930.70
37	504.41	655.74	353.09	958.39
38	519.67	675.57	363.76	987.37
39	535.56	696.23	374.89	1,017.56
40	552.14	717.78	386.50	1,049.06
41	569.44	740.26	398.60	1,081.92
42	587.49	763.74	411.24	1,116.23
43	606.27	788.14	424.38	1,151.91
44	625.85	813.59	438.09	1,189.11
45	646.23	840.09	452.35	1,227.82
46	667.44	867.67	467.21	1,268.14
47	689.50	896.36	482.65	1,310.06
48	712.44	926.18	498.71	1,353.65
49	736.26	957.14	515.39	1,398.90
50	761.04	989.36	532.73	1,445.99
51	786.79	1,022.83	550.75	1,494.90
52	813.53	1,057.60	569.48	1,545.71
53	841.28	1,093.66	588.89	1,598.43
54	870.10	1,131.14	609.07	1,653.20
55	900.01	1,170.02	630.01	1,710.02
56	931.04	1,210.35	651.72	1,768.98
57	963.23	1,252.20	674.26	1,830.13
58	996.57	1,295.56	697.61	1,893.51
59	1,031.17	1,340.52	721.82	1,959.22
60	1,067.04	1,387.15	746.93	2,027.38
61	1,104.20	1,435.46	772.93	2,097.97
62	1,142.67	1,485.46	799.87	2,171.07
63	1,182.54	1,537.32	827.79	2,246.84
64+	1,236.04	1,606.84	865.23	2,348.46

Dental DPO Benefits at a Glance

Plan Features	Humana	
Plan Name	Humana PPO CA	
Services Rendered At	**In Network**	**Out of Network**
Calendar Year Deductible (Individual/Family)	$25 / $75	$50 / $150
Calendar Year Maximum	$1,500 per plan period [22]	
Waiting Period/Major Services	None	
Benefit Levels	Contracted Rate	Contracted Allowance
Preventative Services		
Oral Exams	No Charge (No Deductible)	
Cleanings	No Charge (No Deductible)	
Bitewing X-rays	No Charge (No Deductible)	
Complete X-rays	No Charge (No Deductible)	
Basic Services		
Fillings (composite resin)	10%	20%
Oral Surgery	10%	20%
Major Services		
Crowns (high noble)	40%	50%
Orthodontics		
Lifetime Maximum	$1,000 per child	
Children up to 19th Birthday	50% (No Deductible)	
Adults	Not Covered	
Monthly Rates, effective 12/01/2024		
Employee	60.31	
+Spouse	76.40	
+Child	63.87	
+Children	63.87	
+Family	143.94	
Plan ID	8663	

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[22] After annual maximum is reached, members receive 30% coinsurance on preventive, basic, and major services for the rest of the plan year (excludes orthodontia).

Dental DMO Benefits at a Glance

Plan Features	Humana
Plan Name	Humana DMO LS300
Calendar Year Deductible (Individual/Family)	None
Calendar Year Maximum	None
Waiting Period/Major Services	None
Benefit Levels	Fee Schedule
Preventative Services	
Oral Exams	No Charge
Cleanings	$8 (2 per 12 months) [26]
Bitewing X-rays	No Charge
Complete X-rays	No Charge
Basic Services	
Fillings (composite resin)	$16 Copay
Oral Surgery	$15 Copay [20]
Major Services	
Crowns (high noble)	$185 Copay [39]
Orthodontics	
Lifetime Maximum	Refer to Schedule of Benefits
Children up to 19th Birthday	$1,550 Copay [21]
Adults	$1,695 Copay [21]
Monthly Rates, effective 12/01/2024	
Employee	12.44
+Spouse	9.32
+Child	9.32
+Children	17.62
+Family	17.62
Plan ID	7703

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[20] Surgical removal of erupted tooth, impacted tooth, and tooth root. [21] In order to be covered, orthodontic treatment must be received in one continuous course of treatment; must be received in consecutive months and must not exceed 24 consecutive months. [26] No charge for the first 2 per 12 months. $8 for 3rd or more per 12 months. [39] The total amount chargeable to the member for elective upgraded procedures is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.

Vision Benefits at a Glance

Plan Features	vsp vision care
Plan Name	VSP Standard
Plan ID	10883
Provider	VSP Provider [30]
Eye Exam	$10 Copay
Frames	$20 Copay. $150 plan allowance, 20% off balance over allowance
Lenses	
Single	$20 Copay
Bifocal	$20 Copay
Trifocal	$20 Copay
Contact Lenses (instead of glasses)	$150 plan allowance [31]
Frequency	
Examination	Every 12 months
Frame	Every 24 months
Lenses or Contact Lenses	Every 12 months
Monthly Rates, effective 12/01/2024	
Employee	11.61
+Spouse	2.78
+Child	2.78
+Children	12.17
+Family	12.17
Plan ID	10883

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[30] 20% off for certain materials and services accessed through a VSP provider . [31] Allowance for contacts and contact lens exam (fitting and evaluation).

Voluntary Life and AD&D Benefits at a Glance

Distributed by PIA-SC, Insurance Services Inc.

Plan Features	
Amount	Increments of $10,000
Maximum Amount	Lesser of $500,000 or 10 x Earnings (subject to underwriting)
Guarantee Issue (GIA)	$120,000 maximum without additional underwriting (New Hires only)
Age Reduction (Original Benefit Amount reduced to)	65% at age 70 50% at age 75
Eligibility	Full time employee (of participating employer) and their eligible dependents
Evidence of Insurability (EOI)	EOI is required for all amounts of insurance selected after the initial 31-day eligibility period and for any amount in excess of the GIA.
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the member.
Spouse	
Amount	Increments of $5,000
Maximum Amount	$250,000 not to exceed 100% of employee coverage (subject to underwriting)
Guarantee Issue	$25,000 maximum without additional underwriting
Child	
Child Amount (Birth to 26 yrs.)	$5,000 or maximum of $10,000

Monthly Employee Rates, effective 12/1/2024

Non-Smoker Benefit	$10,000	$50,000	$80,000	$120,000
Under 25	0.86	4.30	6.88	10.32
25-29	0.86	4.30	6.88	10.32
30-34	0.95	4.75	7.60	11.40
35-39	1.05	5.25	8.40	12.60
40-44	1.62	8.10	12.96	19.44
45-49	2.28	11.40	18.24	27.36
50-54	3.33	16.65	26.64	39.96
55-59	5.99	29.95	47.92	71.88
60-64	9.69	48.45	77.52	116.28
65-69	17.48	87.40	139.84	209.76
70-74	35.72	178.60	285.76	428.64
75+	35.72	178.60	285.76	428.64

Smoker Benefit	$10,000	$50,000	$80,000	$120,000
Under 25	1.24	6.20	9.92	14.88
25-29	1.24	6.20	9.92	14.88
30-34	1.33	6.65	10.64	15.96
35-39	1.90	9.50	15.20	22.80
40-44	3.04	15.20	24.32	36.48
45-49	4.75	23.75	38.00	57.00
50-54	7.22	36.10	57.76	86.64
55-59	11.59	57.95	92.72	139.08
60-64	16.82	84.10	134.56	201.84
65-69	26.70	133.50	213.60	320.40
70-74	48.93	244.65	391.44	587.16
75+	48.93	244.65	391.44	587.16

Employee Assistance Program Benefits at a Glance

Plan Features	
Plan Name	EAP
Employee Assistance Program	Counseling services for various life management problems for employees and dependents
Office Visits	$0 copay with authorization
Deductible	None
Clinical Counseling	
Visits	6 visits per incident per plan period, unlimited incidents
Telephone Couseling	As needed
Web Video Couseling	As needed
Monthly Rates, effective 12/01/2024, Employer Sponsored Plan	
Employee	5.80
Plan ID	11643

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