SACRAMENTO ASSOCIATION OF REALTORS®

Member Benefits Program

Ames-Grenz Insurance Services, Inc.

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KAISER PERMANENTE

Effective Date:	December 1, 2014 - November 30, 2015			
BENEFIT	**$15 Copay Plan** **HMO**	**$20 Copay Plan** **HMO**	**$30 Copayment Plan** **HMO**	**$50 Copay Plan** **HMO**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	None	None	None	None
Calendar Year Max Out-of-Pocket Individual / Family	$2,500 / $5,000	$2,500 / $5,000	$3,000 / $6,000	$3,500 / $7,000
Office Visit	$15 copay	$20 copay	$30 copay	$50 copay
Diagnostic X-Ray & Lab	$10 copay	$10 copay	$10 copay	$10 copay
MRI/CT/PET	$50 copay	$50 copay	$50 copay	$50 copay
Preventive Care Exam	$0 copay	$0 copay	$0 copay	$0 copay
Hospitalization	$200 per day	$300 per day	$400 per day	$500 per day
Outpatient Surgery	$100 copay per procedure	$150 copay per procedure	$200 copay per procedure	$250 copay per procedure
Emergency Room	$100 copay	$100 copay	$100 copay	$150 copay
Urgent Care Center	$15 copay	$20 copay	$30 copay	$50 copay
Maternity: Inpatient Prenatal/First Postpartum Visit	 $200 per day No Charge	 $300 per day No Charge	 $400 per day No Charge	 $500 per day No Charge
Mental Health: Inpatient Outpatient	 $200 per day $15 copay	 $300 per day $20 copay	 $400 per day $30 copay	 $500 per day $50 copay
Substance Abuse: Inpatient Detox Only	 $200 per day	 $300 per day	 $400 per day	 $500 per day
Prescriptions	(30 Day Supply)	(30 Day Supply)	(up to 100 Day Supply)	(up to 100 Day Supply)
Generic	$10 copay	$10 copay	$10 copay	$10 copay
Brand Name Deductible	None	None	$250 Deductible	$250 Deductible
Brand	$25 copay	$30 copay	$35 copay after deductible	$35 copay after deductible
Optical (eyewear)	$150 allowance (every 24 months)	No Benefit	No Benefit	No Benefit
Vision exam	$0 copay	$0 copay	$0 copay	$0 copay
Provider Restrictions	Kaiser			

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1, 2014 - November 30, 2014

KAISER PERMANENTE

Effective Date:	December 1, 2014 - November 30, 2015		
BENEFIT	**$30/$1,000 Deductible Plan HMO**	**$30/$1,500 Deductible Plan HMO**	**$40/$2,000 Deductible Plan HMO**
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Calendar Year Deductible (Individual/family)	$1,000 / $2,000 (1)	$1,500 / $3,000 (2)	$2,000 / $4,000 (3)
Calendar Year Max Out-of-Pocket (4) (Individual / Family)	$3,500 / $7,000	$3,500 / $7,000	$4,500 / $9,000
Office Visit	$30 copay (5)	$30 copay (5)	$40 copay (5)
Diagnostic X-Ray & Lab	$10 copay after deductible	$10 copay after deductible	$10 copay after deductible
MRI/CT/PET	$50 copay after deductible	$50 copay after deductible	$50 copay after deductible
Preventive Care Exam	$0 copay (5)	$0 copay (5)	$0 copay (5)
Hospitalization	$500 per day after deductible	$500 per day after deductible	30% per admission after deductible
Outpatient Surgery	$250 copay after deductible	$250 copay after deductible	30% after deductible
Emergency Room	$100 copay after deductible	$100 copay after deductible	30% after deductible
Urgent Care Center	$30 copay after deductible	$30 copay after deductible	$40 copay after deductible
Maternity:			
Inpatient	$500 per day after deductible	$500 per day after deductible	30% per admission after deductible
Prenatal/First Postpartum Visit	No Charge (5)	No Charge (5)	No Charge (5)
Mental Health:			
Inpatient	$500 per day after deductible	$500 per day after deductible	30% per admission after deductible
Outpatient	$30 copay (5)	$30 copay (5)	$40 copay (5)
Substance Abuse:			
Inpatient Detox Only	$500 per day after deductible	$500 per day after deductible	30% per admission after deductible
Prescriptions	(up to 30 Day Supply)	(up to 30 Day Supply)	(up to 30 Day Supply)
Generic	$10 copay (5)	$10 copay (5)	$10 copay (5)
Brand	$30 copay (5)	$30 copay (5)	$35 copay (5)
Optical (eyewear)	No Benefit	No Benefit	No Benefit
Vision exam	$0 copay (5)	$0 copay (5)	$0 copay (5)
Provider Restrictions	Kaiser		

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1, 2014 - November 30, 2014

(1) $1,000 per calendar year for any one Member and $2,000 per calendar year for an entire Family Unit of two or more Members.

(2) $1,500 per calendar year for any one Member and $3,000 per calendar year for an entire Family Unit of two or more Members.

(3) $2,000 per calendar year for any one Member and $4,000 per calendar year for an entire Family Unit of two or more Members.

(4) All Deductible payments count toward the Calendar Year Max Out-of-Pocket.

(5) Not subject to calendar year deductible or calendar year max out-of-pocket.

KAISER PERMANENTE

Effective Date:	December 1, 2014 - November 30, 2015		
BENEFIT	**$0/$2,000 Deductible Plan with HSA HMO**	**$0/$2,700 Deductible Plan with HSA HMO**	**$30/$3,000 Deductible Plan with HSA HMO**
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Calendar Year Deductible (Individual/family)	$2,000 / $4,000 (1)	$2,700 / $5,450 (2)	$3,000 /$6,000 (3)
Calendar Year Max Out-of-Pocket (4) (Individual / Family)	$3,500 / $7,000	$4,500 / $9,000	$5,950 / $11,900
Office Visit	$0 copay after deductible	$0 copay after deductible	$30 copay after deductible
Diagnostic X-Ray & Lab	$0 copay after deductible	$0 copay after deductible	$10 copay after deductible
MRI/CT/PET	$50 copay after deductible	$50 copay after deductible	$50 copay after deductible
Preventive Care Exam	$0 copay (5)	$0 copay (5)	$0 copay (5)
Hospitalization	$300 per day after deductible	$450 per day after deductible	30% per admission after deductible
Outpatient Surgery	$150 copay after deductible	$250 copay after deductible	30% after deductible
Emergency Room	$100 copay after deductible	$100 copay after deductible	30% after deductible
Urgent Care Center	$0 copay after deductible	$0 copay after deductible	$30 copay after deductible
Maternity:			
Inpatient	$300 per day after deductible	$450 per day after deductible	30% per admission after deductible
Prenatal/First Postpartum Visit	No Charge (5)	No Charge (5)	No Charge (5)
Mental Health:			
Inpatient	$300 per day after deductible	$450 per day after deductible	30% per admission after deductible
Outpatient	$0 copay after deductible	$0 copay after deductible	$30 copay after deductible
Substance Abuse:			
Inpatient Detox Only	$300 per day after deductible	$450 per day after deductible	30% per admission after deductible
Prescriptions	(up to 30 Day Supply)	(up to 30 Day Supply)	(up to 30 Day Supply)
Generic	$10 copay after deductible	$10 copay after deductible	$10 copay after deductible
Brand	$30 copay after deductible	$30 copay after deductible	$30 copay after deductible
Optical (eyewear)	No Benefit	No Benefit	No Benefit
Vision exam	$0 copay after deductible	$0 copay after deductible	$30 copay after deductible
Provider Restrictions	Kaiser		

Eligibility Guidelines - GUARANTEED ISSUE

Kaiser Members & Dependents	New Members: May join the 1st of the month following 30 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1, 2014 - November 30, 2014

(1) $2,000 Deductible is for a Single Member enrolled in the plan per calendar year. If you have family coverage, there is no single deductible for each family member; rather, the entire family deductible must be met before Kaiser becomes responsible for providing covered services for any individual member in the family.

(2) $2,700 Deductible is for a Single Member enrolled in the plan per calendar year. If you have family coverage, there is a single deductible for each family member. Each family member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied.

(3) $3,000 Deductible is for a Single Member enrolled in the plan per calendar year. If you have family coverage, there is a single deductible for each family member. Each family member becomes eligible for copayments or coinsurance after meeting the individual deductible, or when the family deductible is satisfied.

(4) All Deductible payments count toward the Calendar Year Max Out-of-Pocket.

(5) Not subject to calendar year deductible or Calendar Year Max Out-of-Pocket.

KAISER MEDICAL PLAN RATES
EFFECTIVE DATE: DECEMBER 01, 2014 - NOVEMBER 30, 2015

The following counties are entirely within Rate Region 1: Alameda, Sacramento, San Francisco, San Joaquin, San Mateo, and Santa Clara. Portions of the following counties are also within Rate Area 1: Amador, Contra Costa, El Dorado, Placer, Sutter, Yolo, and Yuba.

KAISER MEDICAL PLANS

		Traditional Copay Plans				Deductible Plans			HSA Qualified Plans		
	Monthly Rates	$15 Copay	$20 Copay	$30 Copay	$50 Copay	$30/$1000 Deductible Plan	$30/$1500 Deductible Plan	$40/$2000 Deductible Plan	$0/$2000 Deductible Plan	$0/$2700 Deductible Plan	$30/$3000 Deductible Plan
Member Only	<30	$422.00	$396.00	$361.00	$330.00	$307.00	$271.00	$252.00	$270.00	$223.00	$200.00
	30-39	$465.00	$436.00	$397.00	$363.00	$359.00	$317.00	$294.00	$316.00	$260.00	$233.00
	40-49	$594.00	$556.00	$506.00	$462.00	$478.00	$421.00	$390.00	$420.00	$345.00	$307.00
	50-54	$766.00	$718.00	$653.00	$596.00	$632.00	$556.00	$515.00	$554.00	$454.00	$404.00
	55-59	$963.00	$902.00	$820.00	$748.00	$780.00	$685.00	$634.00	$683.00	$559.00	$497.00
	60-64	$1,184.00	$1,108.00	$1,006.00	$917.00	$993.00	$872.00	$807.00	$869.00	$710.00	$631.00
	65+	$1,340.00	$1,254.00	$1,139.00	$1,038.00	$1,201.00	$1,054.00	$975.00	$1,050.00	$857.00	$761.00
Member + Spouse	<30	$1,144.00	$1,071.00	$973.00	$886.00	$806.00	$708.00	$655.00	$705.00	$577.00	$513.00
	30-39	$1,228.00	$1,150.00	$1,044.00	$952.00	$926.00	$813.00	$752.00	$810.00	$662.00	$589.00
	40-49	$1,340.00	$1,254.00	$1,138.00	$1,037.00	$955.00	$838.00	$776.00	$836.00	$683.00	$606.00
	50-54	$1,571.00	$1,471.00	$1,336.00	$1,217.00	$1,290.00	$1,132.00	$1,047.00	$1,128.00	$921.00	$817.00
	55-59	$2,001.00	$1,872.00	$1,700.00	$1,548.00	$1,600.00	$1,403.00	$1,297.00	$1,398.00	$1,140.00	$1,011.00
	60-64	$2,231.00	$2,087.00	$1,893.00	$1,724.00	$1,968.00	$1,725.00	$1,595.00	$1,719.00	$1,401.00	$1,243.00
	65+	$2,872.00	$2,686.00	$2,438.00	$2,219.00	$2,712.00	$2,377.00	$2,197.00	$2,369.00	$1,929.00	$1,709.00
Member + Child(ren)	<30	$1,125.00	$1,053.00	$957.00	$872.00	$669.00	$588.00	$545.00	$586.00	$480.00	$427.00
	30-39	$1,157.00	$1,083.00	$983.00	$896.00	$704.00	$619.00	$573.00	$617.00	$505.00	$450.00
	40-49	$1,110.00	$1,039.00	$944.00	$860.00	$736.00	$647.00	$599.00	$645.00	$528.00	$469.00
	50-54	$1,251.00	$1,171.00	$1,064.00	$970.00	$858.00	$754.00	$698.00	$751.00	$614.00	$546.00
	55-59	$1,430.00	$1,338.00	$1,216.00	$1,108.00	$1,005.00	$882.00	$816.00	$879.00	$719.00	$638.00
	60-64	$1,577.00	$1,475.00	$1,339.00	$1,220.00	$1,223.00	$1,073.00	$993.00	$1,070.00	$873.00	$775.00
	65+	$2,004.00	$1,875.00	$1,702.00	$1,550.00	$1,422.00	$1,247.00	$1,153.00	$1,242.00	$1,013.00	$899.00
Member + Family	<30	$1,584.00	$1,483.00	$1,346.00	$1,225.00	$967.00	$849.00	$785.00	$845.00	$691.00	$614.00
	30-39	$1,749.00	$1,637.00	$1,486.00	$1,354.00	$1,081.00	$948.00	$877.00	$945.00	$772.00	$686.00
	40-49	$1,762.00	$1,648.00	$1,496.00	$1,362.00	$1,208.00	$1,059.00	$981.00	$1,057.00	$862.00	$765.00
	50-54	$2,003.00	$1,875.00	$1,702.00	$1,550.00	$1,426.00	$1,251.00	$1,157.00	$1,247.00	$1,017.00	$902.00
	55-59	$2,298.00	$2,150.00	$1,952.00	$1,777.00	$1,752.00	$1,536.00	$1,420.00	$1,531.00	$1,248.00	$1,106.00
	60-64	$2,601.00	$2,433.00	$2,207.00	$2,009.00	$2,175.00	$1,907.00	$1,763.00	$1,900.00	$1,548.00	$1,373.00
	65+	$3,155.00	$2,951.00	$2,678.00	$2,437.00	$2,844.00	$2,493.00	$2,304.00	$2,484.00	$2,023.00	$1,792.00

KAISER MEDICAL PLAN RATES
EFFECTIVE DATE: DECEMBER 01, 2014 - NOVEMBER 30, 2015

The following counties are entirely within Rate Areas 2 and 3: Marin, Napa, Solano, and Stanislaus. Portions of the following counties are also within Rate Areas 2 and 3: Contra Costa, Fresno, Kings, Madera, Mariposa, Sonoma, and Tulare.

KAISER MEDICAL PLANS

		Traditional Copay Plans				Deductible Plans			HSA Qualified Plans		
	Monthly Rates	$15 Copay	$20 Copay	$30 Copay	$50 Copay	$30/$1000 Deductible Plan	$30/$1500 Deductible Plan	$40/$2000 Deductible Plan	$0/$2000 Deductible Plan	$0/$2700 Deductible Plan	$30/$3000 Deductible Plan
Member Only	<30	$444.00	$416.00	$379.00	$347.00	$322.00	$284.00	$264.00	$283.00	$234.00	$209.00
	30-39	$488.00	$458.00	$417.00	$381.00	$377.00	$332.00	$308.00	$331.00	$273.00	$244.00
	40-49	$624.00	$584.00	$532.00	$486.00	$502.00	$442.00	$410.00	$441.00	$362.00	$323.00
	50-54	$806.00	$755.00	$686.00	$626.00	$664.00	$584.00	$541.00	$582.00	$477.00	$424.00
	55-59	$1,013.00	$949.00	$862.00	$786.00	$820.00	$720.00	$667.00	$718.00	$587.00	$522.00
	60-64	$1,245.00	$1,165.00	$1,058.00	$964.00	$1,045.00	$917.00	$849.00	$914.00	$747.00	$663.00
	65+	$1,409.00	$1,319.00	$1,198.00	$1,091.00	$1,263.00	$1,108.00	$1,025.00	$1,104.00	$901.00	$800.00
Member + Spouse	<30	$1,204.00	$1,126.00	$1,023.00	$933.00	$847.00	$743.00	$688.00	$741.00	$606.00	$538.00
	30-39	$1,292.00	$1,209.00	$1,098.00	$1,001.00	$973.00	$854.00	$790.00	$851.00	$696.00	$618.00
	40-49	$1,409.00	$1,318.00	$1,198.00	$1,092.00	$1,004.00	$881.00	$816.00	$879.00	$718.00	$638.00
	50-54	$1,654.00	$1,547.00	$1,404.00	$1,280.00	$1,357.00	$1,191.00	$1,101.00	$1,187.00	$968.00	$859.00
	55-59	$2,105.00	$1,970.00	$1,788.00	$1,628.00	$1,683.00	$1,476.00	$1,365.00	$1,471.00	$1,199.00	$1,064.00
	60-64	$2,347.00	$2,195.00	$1,992.00	$1,814.00	$2,071.00	$1,815.00	$1,679.00	$1,809.00	$1,475.00	$1,307.00
	65+	$3,022.00	$2,827.00	$2,565.00	$2,335.00	$2,854.00	$2,501.00	$2,312.00	$2,492.00	$2,029.00	$1,798.00
Member + Child(ren)	<30	$1,184.00	$1,108.00	$1,006.00	$918.00	$703.00	$618.00	$572.00	$616.00	$504.00	$448.00
	30-39	$1,216.00	$1,139.00	$1,034.00	$943.00	$740.00	$650.00	$602.00	$648.00	$531.00	$472.00
	40-49	$1,167.00	$1,092.00	$993.00	$905.00	$774.00	$680.00	$630.00	$678.00	$555.00	$494.00
	50-54	$1,316.00	$1,232.00	$1,118.00	$1,019.00	$902.00	$792.00	$733.00	$790.00	$646.00	$573.00
	55-59	$1,504.00	$1,408.00	$1,279.00	$1,165.00	$1,057.00	$928.00	$859.00	$925.00	$755.00	$671.00
	60-64	$1,658.00	$1,551.00	$1,408.00	$1,283.00	$1,287.00	$1,129.00	$1,045.00	$1,125.00	$919.00	$815.00
	65+	$2,108.00	$1,973.00	$1,791.00	$1,630.00	$1,495.00	$1,311.00	$1,213.00	$1,307.00	$1,066.00	$946.00
Member + Family	<30	$1,667.00	$1,559.00	$1,416.00	$1,290.00	$1,016.00	$891.00	$825.00	$889.00	$726.00	$644.00
	30-39	$1,840.00	$1,722.00	$1,563.00	$1,424.00	$1,136.00	$996.00	$922.00	$993.00	$811.00	$720.00
	40-49	$1,853.00	$1,733.00	$1,575.00	$1,434.00	$1,270.00	$1,114.00	$1,031.00	$1,111.00	$907.00	$805.00
	50-54	$2,108.00	$1,972.00	$1,789.00	$1,630.00	$1,500.00	$1,316.00	$1,217.00	$1,312.00	$1,069.00	$949.00
	55-59	$2,418.00	$2,263.00	$2,053.00	$1,869.00	$1,843.00	$1,616.00	$1,494.00	$1,611.00	$1,312.00	$1,164.00
	60-64	$2,736.00	$2,559.00	$2,322.00	$2,114.00	$2,289.00	$2,006.00	$1,856.00	$2,000.00	$1,630.00	$1,444.00
	65+	$3,320.00	$3,106.00	$2,818.00	$2,565.00	$2,993.00	$2,623.00	$2,424.00	$2,613.00	$2,128.00	$1,885.00

WESTERN HEALTH ADVANTAGE

Effective Date:	December 1, 2014 - November 30, 2015				
BENEFIT	**Advantage 15-30 Rx H** **HMO**	**Advantage 70 Rx H** **HMO**	**Western 1800** **HSA Compatible Plan** **HMO**	**Western 2800** **HSA Compatible Plan** **HMO**	**Western 4010** **HMO**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Calendar Year Deductible Individual / Family	None	None	$1,800 / $3,600 (1)	$2,800 / $5,600 (2)	$1,000 / $2,000
Calendar Year Max Out-of-Pocket Individual / Family	$1,500 / $2,500	$3,000 / $5,000	$1,800 / $3,600 (3)	$4,000 / $8,000 (3)	$4,000 / $8,000
Office Visit	$15-$30 copay (6)	$20 copay	No Charge after Deductible	$40 copay after Deductible	$40 copay
Diagnostic X-Ray & Lab	No Charge	No Charge	No Charge after Deductible	No Charge after Deductible	No Charge
Periodic Physical Exam	No Charge (5)	No Charge (5)	No Charge (4,5)	No Charge (4,5)	No Charge (4,5)
Hospitalization	$250 per day (days 1-3)	30% copay	No Charge after Deductible	$500 per day after Deductible	$500 per day after Deductible
Outpatient Surgery Facility	$100 copay	30% copay	No Charge after Deductible	$250 copay after Deductible	$250 copay after Deductible
Outpatient Surgery Office Setting	$15-$30 copay (6)	$20 copay	No Charge after Deductible	$40 copay after Deductible	$40 copay
Emergency Room	$100 copay	$100 copay	No Charge after Deductible	$100 copay after Deductible	$100 copay after Deductible
Urgent Care Center	$50 copay	$50 copay	No Charge after Deductible	$50 copay after Deductible	$50 copay
Maternity:					
Inpatient	$250 per day (days 1-3)	30% copay	No Charge after Deductible	$500 per day after Deductible	$500 per day after Deductible
Prenatal/First Postpartum Visit	No Charge	No Charge	No Charge (4)	No Charge (4)	No Charge (4)
Mental Health:					
Inpatient	$250 per day (days 1-3)	30% copay	No Charge after Deductible	$500 per day after Deductible	$500 per day after Deductible
Outpatient	$15 copay	$20 copay	No Charge after Deductible	$40 copay visits after Deductible	$40 copay
Substance Abuse:					
Inpatient Detox Only	$250 per day (days 1-3)	30% copay	No Charge after Deductible	$500 per day after Deductible	$500 per day after Deductible
Prescriptions	(30 Day Supply)	(30 Day Supply)	(30 Day Supply)	(30 Day Supply)	(30 Day Supply)
Generic	$10 copay	$10 copay	No Charge after Deductible	$10 copay after Deductible	$10 copay
Deductible (Brand Name)	None	None	$1,800 / $3,600	$2,800 / $5,600	$150 per Member
Brand	$30 copay	$30 copay	No Charge after Deductible	$30 copay after Deductible	$30 copay after Deductible
Non Formulary	$50 copay	$50 copay	No Charge after Deductible	$50 copay after Deductible	$50 copay after Deductible
Optical (eyewear)	No Benefit	No Benefit	No Benefit	No Benefit	No Benefit
Vision exam	$15-$30 copay (6)	$20 copay	No Charge (4)	$40 copay (4)	$40 copay (4)
Provider Restrictions	Western Health Advantage HMO				

Eligibility Guidelines - GUARANTEED ISSUE

WHA Members & Dependents	Members may apply at anytime except if you are a new member, then it is the 1st of the month following new membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26.
Open Enrollment	November 1, 2013 - November 30, 2013

(1) $1,800 Deductible is for a Single Member enrolled in plan per calendar year. If you have family coverage, there is no single deductible for each family member; rather, the entire family deductible must be met before WHA becomes responsible for providing covered services for any individual member in the family.

(2) $2,800 Deductible is for a Single Member enrolled in plan per calendar year. If you have family coverage, there is no single deductible for each family member; rather, the entire family deductible must be met before WHA becomes responsible for providing covered services for any individual member in the family.

(3) All Deductible payments count toward the Calendar Year Max Out-of-Pocket.

(4) Not subject to calendar year deductible.

(5) See EOB for more details.

(6) Primary Care Physician copay $15 - Specialist copay $30

WESTERN HEALTH ADVANTAGE MEDICAL PLANS

EFFECTIVE DATE: DECEMBER 01, 2014 - NOVEMBER 30, 2015

The following counties are entirely within Rate Regions 1 and 3: El Dorado, Placer, Sacramento, Solano and Yolo.

		Copay Plans		HSA Qualified Plans		High Deductible Plan
	Monthly Rates	Advantage 15-30 Rx H	Advantage 70 Rx H	Western 1800 HSA	Western 2800 HSA	Western 4010
Member Only	<30	$489.69	$420.33	$304.34	$222.13	$314.50
	30-39	$554.91	$475.92	$360.58	$262.04	$372.74
	40-49	$651.88	$558.57	$503.22	$363.44	$520.47
	50-54	$874.80	$748.56	$644.97	$464.18	$667.28
	55-59	$1,053.45	$900.82	$815.27	$585.22	$843.65
	60-64	$1,275.26	$1,089.89	$1,014.10	$726.53	$1,049.60
	65+	$1,270.77	$1,086.02	$1,212.91	$867.85	$1,255.50
Member + Spouse	<30	$1,016.61	$869.40	$779.18	$559.60	$806.28
	30-39	$1,174.35	$1,003.90	$893.31	$640.65	$924.49
	40-49	$1,393.83	$1,190.98	$968.79	$694.32	$1,002.66
	50-54	$1,729.08	$1,476.67	$1,234.71	$883.33	$1,278.07
	55-59	$2,029.73	$1,732.94	$1,538.43	$1,099.19	$1,592.63
	60-64	$2,478.97	$2,115.83	$1,918.43	$1,369.25	$1,986.20
	65+	$2,513.56	$2,145.31	$2,450.26	$1,747.28	$2,537.01
Member + Child(ren)	<30	$1,162.64	$993.88	$633.21	$455.84	$655.10
	30-39	$1,261.23	$1,077.90	$664.25	$477.90	$687.24
	40-49	$1,315.82	$1,124.48	$695.33	$499.97	$719.44
	50-54	$1,538.82	$1,314.53	$817.81	$587.03	$846.30
	55-59	$1,734.00	$1,480.88	$940.31	$674.08	$973.16
	60-64	$2,032.99	$1,735.70	$1,154.99	$826.67	$1,195.51
	65+	$2,026.29	$1,729.99	$1,339.60	$957.88	$1,386.71
Member + Family	<30	$1,709.09	$1,459.63	$1,021.64	$731.91	$1,057.40
	30-39	$1,970.79	$1,682.68	$1,171.83	$838.60	$1,212.95
	40-49	$2,112.59	$1,803.54	$1,271.62	$909.58	$1,316.31
	50-54	$2,338.98	$1,996.54	$1,472.14	$1,052.05	$1,523.98
	55-59	$2,562.30	$2,186.88	$1,722.13	$1,229.74	$1,782.90
	60-64	$3,021.51	$2,578.25	$2,072.80	$1,478.97	$2,146.08
	65+	$3,022.70	$2,579.24	$2,623.09	$1,870.12	$2,716.01

WESTERN HEALTH ADVANTAGE MEDICAL PLANS

EFFECTIVE DATE: DECEMBER 01, 2014 - NOVEMBER 30, 2015

The following counties are entirely within Rate Regions 2: Marin, Napa, and Sonoma

		Copay Plans		HSA Qualified Plans		High Deductible Plan
	Monthly Rates	Advantage 15-30 Rx H	Advantage 70 Rx H	Western 1800 HSA	Western 2800 HSA	Western 4010
Member Only	<30	$517.87	$444.35	$321.40	$234.26	$332.17
	30-39	$587.00	$503.28	$381.01	$276.56	$393.90
	40-49	$689.79	$590.88	$532.21	$384.05	$550.50
	50-54	$926.09	$792.27	$682.47	$490.83	$706.12
	55-59	$1,115.46	$953.67	$862.99	$619.13	$893.07
	60-64	$1,350.58	$1,154.08	$1,073.75	$768.92	$1,111.38
	65+	$1,345.82	$1,149.98	$1,284.48	$918.72	$1,329.63
Member + Spouse	<30	$1,076.41	$920.36	$824.73	$591.98	$853.46
	30-39	$1,243.61	$1,062.93	$945.71	$677.89	$978.76
	40-49	$1,476.26	$1,261.24	$1,025.72	$734.78	$1,061.62
	50-54	$1,831.62	$1,564.07	$1,307.59	$935.13	$1,353.55
	55-59	$2,150.31	$1,835.72	$1,629.54	$1,163.94	$1,686.99
	60-64	$2,626.51	$2,241.58	$2,032.34	$1,450.21	$2,104.17
	65+	$2,663.17	$2,272.83	$2,596.08	$1,850.92	$2,688.03
Member + Child(ren)	<30	$1,231.20	$1,052.31	$670.00	$481.99	$693.21
	30-39	$1,335.70	$1,141.37	$702.91	$505.37	$727.27
	40-49	$1,393.57	$1,190.75	$735.85	$528.77	$761.41
	50-54	$1,629.95	$1,392.20	$865.68	$621.05	$895.88
	55-59	$1,836.84	$1,568.53	$995.53	$713.32	$1,030.35
	60-64	$2,153.77	$1,838.64	$1,223.09	$875.07	$1,266.04
	65+	$2,146.67	$1,832.59	$1,418.78	$1,014.15	$1,468.71
Member + Family	<30	$1,810.44	$1,546.01	$1,081.74	$774.62	$1,119.64
	30-39	$2,087.84	$1,782.44	$1,240.94	$887.72	$1,284.53
	40-49	$2,238.15	$1,910.55	$1,346.72	$962.95	$1,394.09
	50-54	$2,478.12	$2,115.13	$1,559.27	$1,113.97	$1,614.22
	55-59	$2,714.84	$2,316.89	$1,824.26	$1,302.32	$1,888.67
	60-64	$3,201.60	$2,731.75	$2,195.97	$1,566.51	$2,273.64
	65+	$3,202.86	$2,732.79	$2,779.28	$1,981.13	$2,877.77

Anthem Blue Cross of California - Effective June 1, 2014 to May 31, 2015

Benefits shown are for Preferred Providers *ONLY. Benefits shown are always based on the Blue Cross Allowed amount.*

Benefits for Non Preferred Providers are significantly reduced.

EFFECTIVE DATE	December 1, 2014 - November 30, 2015				
MAPPED FROM	Saver HMO $20			$30 Copay Plan	$35 GenRx Plan
PLAN NAME	Preferred Gold	Essential Silver 1500 Plus	Preferred Gold 500	Preferred Gold 1500	Preferred Gold 1000
PLAN CODE	gzba	gboa	gwfa	gyfa	gzfa
PLAN TYPE	HMO	HMO	PPO	PPO	PPO
MAX LIFETIME BENEFIT	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
DEDUCTIBLE (A): Member	None	$1,500	$500/$1,000	$1,500/$3,000	$1,000/$2,000
DEDUCTIBLE (A): Family	None	$3,000	$1,000/$2,000	$3,000/$6,000	$2,000/$4,000
OUT OF POCKET MAX (A): Member	$5,500	$6,350	$4,500/$9,000	$3,500/$7,000	$4,500/$9,000
OUT OF POCKET MAX (A): Family	$11,000	$12,700	$9,000/$18,000	$7,000/$14,000	$9,000/$18,000
(A) The plan includes an aggregate embedded accumulation for the family deductible and out-of-pocket maximum. This means that the family amounts can be met by any combination of amounts from any family member, however deductible can be met for one member of the family as soon as that one member satisfies the individual deductible or out of pocket amounts. (1) Subject to Deductible (2) Not Subject to Deductible (3) Payment limited to $380/admission (4) Payment limited to $800 per admission (5) Payment limited to $650/day					
DOCTOR OFFICE VISIT	$35 copay	$50 copay (1)	$30 copay (1)/50% (1)	$20 copay (1)/50% (1)	$20 copay (1)/50% (1)
DIAGNOSTIC SERVICES: LAB	No Charge	30% copay (1)	20% (1)/50% (1, 3)	20% (1)/50% (1, 3)	20% (1)/50% (1, 3)
DIAGNOSTIC SERVICES: X-ray	No Charge	30% copay (1)	20% (1)/50% (1, 3)	20% (1)/50% (1, 3)	20% (1)/50% (1, 3)
ADVANCED IMAGING: MRI/CT/CAT/PET	$250 copay	30% copay (1)	20% (1)/50% (1, 4)	20% (1)/50% (1, 4)	20% (1)/50% (1, 4)
PHYSICAL EXAM Routine	No Charge	No Charge (2)	No Charge (2)/50% (1)	No Charge (2)/50% (1)	No Charge (2)/50% (1)
HOSPITALIZATION (Facility)	$750/day, up to 3 days	30% copay (1)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)
OUTPATIENT Surgery (Facility)	$250 copay/surgery	30% copay (1)	20% (1)/50% (1, 3)	20% (1)/50% (1, 3)	20% (1)/50% (1, 3)
EMERGENCY Room:	$250 copay	$250 copay+30% (1)	$200 copay+20% (1)	$200 copay+20% (1)	$200 copay+20% (1)
AMBULANCE	20% copay	30% copay (1)	20% copay (1)	20% copay (1)	20% copay (1)
MATERNITY:					
Prenatal & Postnatal	No Charge	No Charge (2)	No Charge (2)/50% (1)	No Charge (2)/50% (1)	No Charge (2)/50% (1)
Hospitalization	$750/day, up to 3 days	30% copay (1)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)
MENTAL HEALTH					
Inpatient	$750/day, up to 3 days	30% copay (1)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)
Outpatient	$35 copay	$50 copay (1)	$30 copay (1)/50% (1)	$20 copay (1)/50% (1)	$20 copay (1)/50% (1)
SUBSTANCE ABUSE					
Inpatient Detoxification	$750/day, up to 3 days	30% copay (1)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)	20% (1)/50% (1, 5)
Outpatient	$35 copay	$50 copay (1)	$30 copay (1)/50% (1)	$20 copay (1)/50% (1)	$20 copay (1)/50% (1)
PRESCRIPTION 30 day supply					
Brand Name Deductible	$250/member ($500/family)	$500/member ($1,000/family)	$250/member ($500/family)	None	$250/member ($500/family)
Generic	$15 copay	$15 copay	$15 copay/50%	$15 copay (2)/50%	$15 copay/50%
Brand	$35 copay after Rx Ded	$35 copay after Rx Ded	$35 copay after Rx Ded/50%	$35 copay (2)/50%	$35 copay after Rx Ded/50%
Non-formulary	$70 copay after Rx Ded	$70 copay after Rx Ded	$75 copay after Rx Ded/50%	$70 copay (2)/50%	$75 copay after Rx Ded/50%

Eligibility Guidelines - GUARANTEED ISSUE

Application Requirements	New Members: May join the 1st of the month following 60 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26. OPEN ENROLLMENT; May 1, 2014 to May 31, 2014

*** Must have local and statewide memberships to be eligible for benefits through Anthem.**

Anthem Blue Cross of California - Effective June 1, 2014 to May 31, 2015

Benefits shown are for Preferred Providers *ONLY*. *Benefits shown are always based on the Blue Cross Allowed amount.*

Benefits for Non Preferred Providers are significantly reduced.

EFFECTIVE DATE	December 1, 2014 - November 30, 2015			
MAPPED FROM			Lumenos HSA 3500	
PLAN NAME	Essential Silver 1500	Essential Silver Plus 2000	Core Bronze HSA 3500	Core Bronze HSA 5500
PLAN CODE	gtob	gbqa	gjua	gmua
PLAN TYPE	PPO	PPO	PPO-.HSA	PPO-.HSA
MAX LIFETIME BENEFIT	Unlimited	Unlimited	Unlimited	Unlimited
DEDUCTIBLE (A): Member	$1,500/$3,000	$2,000/$4,000	$3,500/$7,000	$5,500/$11,000
DEDUCTIBLE (A): Family	$3,000/$6,000	$4,000/$8,000	$7,000/$14,000	$11,000/$22,000
OUT OF POCKET MAX (A): Member	$6,350/$12,400	$4,500/$9,000	$6,350/$12,700	$5,500/$11,000
OUT OF POCKET MAX (A): Family	$12,4000/$24,8000	$9,000/$18,000	$12,700/$24,500	$11,000/$22,000
(A) The plan includes an aggregate embedded accumulation for the family deductible and out-of-pocket maximum. This means that the family amounts can be met by any combination of amounts from any family member, however deductible can be met for one member of the family as soon as that one member satisfies the individual deductible or out of pocket (1) Subject to Deductible (2) Not Subject to Deductible (3) Payment limited to $380/admission (4) Payment limited to $800 per admission (5) Payment limited to $650/day				
DOCTOR OFFICE VISIT	$35 copay (1)/50% (1)	$30 copay First 3 visits (2)/50% (1)	30% (1)/50% (1)	No Charge (1)/50% (1)
SUBSEQUENT OFFICE VISITS	$35 copay (1)/50% (1)	30% (1)/50% (1)	30% (1)/50% (1)	No Charge (1)/50% (1)
DIAGNOSTIC SERVICES: LAB	30% (1)/50% (1, 3)	30% (1)/50% (1, 3)	30% (1)/50% (1, 3)	No Charge (1)/50% (1, 3)
DIAGNOSTIC SERVICES: X-ray	30% (1)/50% (1, 3)	30% (1)/50% (1, 3)	30% (1)/50% (1, 3)	No Charge (1)/50% (1, 3)
ADVANCED IMAGING: MRI/CT/CAT/PET	30% (1)/50% (1, 4)	30% (1)/50% (1, 4)	30% (1)/50% (1, 4)	No Charge (1)/50% (1, 4)
PHYSICAL EXAM Routine	No Charge (2)/50% (1)	No Charge (2)/50% (1)	No Charge (2)/50% (1)	No Charge (2)/50% (1)
HOSPITALIZATION (Facility)	30% (1)/50% (1, 5)	30%+$250 copay (1)/50% (1, 5)	30% (1)/50% (1, 5)	No Charge (1)/50% (1, 5)
OUTPATIENT Surgery (Facility)	30% (1)/50% (1, 3)	30%+$250 copay (1)/50% (1, 3)	30% (1)/50% (1, 3)	No Charge (1)/50% (1, 3)
EMERGENCY Room:	30% (1)	$250+30% (1)	30% (1)	No Charge (1)
AMBULANCE	30% (1)	30% (1)	30% (1)	No Charge (1)
MATERNITY:				
Prenatal & Postnatal	No Charge (2)/50% (1)	No Charge (2)/50% (1)	No Charge (2)/50% (1)	No Charge (2)/50% (1)
Hospitalization	30% (1)/50% (1, 5)	30%+$250 copay (1)/50% (1, 5)	30% (1)/50% (1, 5)	No Charge (1)/50% (1, 5)
MENTAL HEALTH				
Inpatient	30% (1)/50% (1, 5)	30%+$250 copay (1)/50% (1, 5)	30% (1)/50% (1, 5)	No Charge (2)/50% (1)
Outpatient	$35 copay (1)/50% (1)	$30 copay First 3 visits (2)/50% (1)	30% (1)/50% (1)	No Charge (1)/50% (1)
SUBSTANCE ABUSE				
Inpatient Detoxification	30% (1)/50% (1, 5)	30%+$250 copay (1)/50% (1, 5)	30% (1)/50% (1, 5)	No Charge (2)/50% (1)
Outpatient	$35 copay (1)/50% (1)	$30 copay First 3 visits (2)/50% (1)	30% (1)/50% (1)	No Charge (1)/50% (1)
PRESCRIPTION 30 day supply				
Brand Name Deductible	$250/member ($500/family)	None	Subject to Plan Deductible	Subject to Plan Deductible
Generic	$15 copay after Rx Ded/50%	$15 copay/50%	30% (1)/50% (1)	No Charge (1)/50% (1)
Brand	$35 copay after Rx Ded/50%	$35 copay/50%	30% (1)/50% (1)	No Charge (1)/50% (1)
Non-formulary	$70 copay after Rx Ded/50%	$70 copay/50%	30% (1)/50% (1)	No Charge (1)/50% (1)

Eligibility Guidelines - GUARANTEED ISSUE

Application Requirements	New Members: May join the 1st of the month following 60 days of membership. Qualifying Events: you may join within 30 days after you have a

*** Must have local and statewide memberships to be eligible for benefits through Anthem.**

Anthem Blue Cross of California - Effective June 1, 2014 to May 31, 2015

Benefits shown are for Preferred Providers *ONLY. Benefits shown are always based on the Blue Cross Allowed amount.*

Benefits for Non Preferred Providers are significantly reduced.

EFFECTIVE DATE	December 1, 2014 - November 30, 2015	
PLAN NAME	Core Bronze HSA 4500	Core Bronze 5500 Plus
PLAN CODE	gpua	gsdf
PLAN TYPE	PPO-HSA	PPO-NON-HSA
MAX LIFETIME BENEFIT	Unlimited	Unlimited
DEDUCTIBLE (A): Member	$4,500/$9,000	$5,500/$11,000
DEDUCTIBLE (A): Family	$9,000/$18,000	$11,000/$22,000
OUT OF POCKET MAX (A): Member	$6,350/$12,700	$6,350/$12,700
OUT OF POCKET MAX (A): Family	$12,7000/$25,400	$12,7000/$25,400
(A) The plan includes an aggregate embedded accumulation for the family deductible and out-of-pocket maximum. This means that the family amounts can be met by any combination of amounts from any family member, however deductible can be met for one member of the family as soon as that one member satisfies the individual deductible or out of pocket amounts. (1) Subject to Deductible (2) Not Subject to Deductible (3) Payment limited to $380/admission (4) Payment limited to $800 per admission (5) Payment limited to $650/day		
DOCTOR OFFICE VISIT	20% (1)/50% (1)	$50 copay First 3 visits (2)/50% (1)
SUBSEQUENT OFFICE VISITS	20% (1)/50% (1)	35% (1)/50% (1)
DIAGNOSTIC SERVICES: LAB	20% (1)/50% (1, 3)	35% (1)/50% (1, 3)
DIAGNOSTIC SERVICES: X-ray	20% (1)/50% (1, 3)	35% (1)/50% (1, 3)
ADVANCED IMAGING: MRI/CT/CAT/PET	20% (1)/50% (1, 4)	35%+$450 copay(1)/50% (1, 4)
PHYSICAL EXAM Routine	No Charge (2)/50% (1)	No Charge (2)/50% (1)
HOSPITALIZATION (Facility)	20% (1)/50% (1, 5)	35% +$1,000 (1)/50% (1, 5)
OUTPATIENT Surgery (Facility)	20% (1)/50% (1, 3)	35%+$450 copay(1)/50% (1, 4)
EMERGENCY Room:	20% (1)	$300 copay+35% (1)
AMBULANCE	20% (1)	35% (1)
MATERNITY:		
Prenatal & Postnatal	No Charge (2)/50% (1)	No Charge (2)/50% (1)
Hospitalization	20% (1)/50% (1, 5)	35% +$1,000 (1)/50% (1, 5)
MENTAL HEALTH		
Inpatient	20% (1)/50% (1, 5)	35% +$1,000 (1)/50% (1, 5)
Outpatient	20% (1)/50% (1)	$50 copay First 3 visits (2)/50% (1)
SUBSTANCE ABUSE		
Inpatient Detoxification	20% (1)/50% (1, 5)	35% +$1,000 (1)/50% (1, 5)
Outpatient	20% (1)/50% (1)	$50 copay First 3 visits (2)/50% (1)
PRESCRIPTION 30 day supply		
Brand Name Deductible	Subject to Plan Deductible	$250/member ($500/Family)
Generic	20% (1)/50% (1)	$19 copay after Rx Ded/50%
Brand	20% (1)/50% (1)	$50 copay after Rx Ded/50%
Non-formulary	20% (1)/50% (1)	$90 copay after Rx Ded/50%

Eligibility Guidelines - GUARANTEED ISSUE

Application Requirements	New Members: May join the 1st of the month following 60 days of membership. Qualifying Events: you may join within 30 days after you have a loss of coverage, marriage, birth or adoption. Over Age Dependents: may remain on coverage up to age 26. OPEN ENROLLMENT; May 1, 2014 to May 31, 2014

*** Must have local and statewide memberships to be eligible for benefits through Anthem.**

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 1

Rates Effective 6/1/14 through 5/31/15

Region 1 includes the counties of: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$321.82	$249.14	$229.83	$228.07	$207.29	$198.13	$184.67	$161.70	$160.50	$154.76	$151.95
21	$506.80	$392.34	$361.93	$359.17	$326.44	$312.02	$290.82	$254.64	$252.75	$243.71	$239.29
22	$506.80	$392.34	$361.93	$359.17	$326.44	$312.02	$290.82	$254.64	$252.75	$243.71	$239.29
23	$506.80	$392.34	$361.93	$359.17	$326.44	$312.02	$290.82	$254.64	$252.75	$243.71	$239.29
24	$506.80	$392.34	$361.93	$359.17	$326.44	$312.02	$290.82	$254.64	$252.75	$243.71	$239.29
25	$508.83	$393.91	$363.38	$360.61	$327.75	$313.27	$291.98	$255.66	$253.76	$244.68	$240.25
26	$518.96	$401.76	$370.62	$367.79	$334.27	$319.51	$297.80	$260.75	$258.82	$249.56	$245.03
27	$531.13	$411.17	$379.30	$376.41	$342.11	$327.00	$304.78	$266.86	$264.88	$255.41	$250.78
28	$550.89	$426.47	$393.42	$390.42	$354.84	$339.17	$316.12	$276.79	$274.74	$264.91	$260.11
29	$567.11	$439.03	$405.00	$401.91	$365.29	$349.15	$325.43	$284.94	$282.83	$272.71	$267.77
30	$575.22	$445.31	$410.79	$407.66	$370.51	$354.14	$330.08	$289.02	$286.87	$276.61	$271.59
31	$587.38	$454.72	$419.48	$416.28	$378.34	$361.63	$337.06	$295.13	$292.94	$282.46	$277.34
32	$599.54	$464.14	$428.16	$424.90	$386.18	$369.12	$344.04	$301.24	$299.00	$288.31	$283.08
33	$607.15	$470.02	$433.59	$430.29	$391.08	$373.80	$348.40	$305.06	$302.79	$291.96	$286.67
34	$615.26	$476.30	$439.38	$436.03	$396.30	$378.79	$353.06	$309.13	$306.84	$295.86	$290.50
35	$619.31	$479.44	$442.28	$438.91	$398.91	$381.29	$355.38	$311.17	$308.86	$297.81	$292.41
36	$623.36	$482.58	$445.17	$441.78	$401.52	$383.78	$357.71	$313.21	$310.88	$299.76	$294.33
37	$627.42	$485.72	$448.07	$444.65	$404.13	$386.28	$360.04	$315.24	$312.90	$301.71	$296.24
38	$631.47	$488.86	$450.96	$447.53	$406.74	$388.78	$362.36	$317.28	$314.93	$303.66	$298.16
39	$639.58	$495.13	$456.76	$453.27	$411.97	$393.77	$367.01	$321.36	$318.97	$307.56	$301.98
40	$647.69	$501.41	$462.55	$459.02	$417.19	$398.76	$371.67	$325.43	$323.01	$311.46	$305.81
41	$659.85	$510.83	$471.23	$467.64	$425.02	$406.25	$378.65	$331.54	$329.08	$317.31	$311.56
42	$671.51	$519.85	$479.56	$475.90	$432.53	$413.43	$385.34	$337.40	$334.89	$322.92	$317.06
43	$687.73	$532.41	$491.14	$487.39	$442.98	$423.41	$394.64	$345.55	$342.98	$330.71	$324.72
44	$708.00	$548.10	$505.62	$501.76	$456.04	$435.89	$406.28	$355.73	$353.09	$340.46	$334.29
45	$731.82	$566.54	$522.63	$518.64	$471.38	$450.56	$419.94	$367.70	$364.97	$351.92	$345.53
46	$760.20	$588.51	$542.90	$538.76	$489.66	$468.03	$436.23	$381.96	$379.13	$365.57	$358.94
47	$792.13	$613.23	$565.70	$561.38	$510.23	$487.69	$454.55	$398.00	$395.05	$380.92	$374.01
48	$828.62	$641.48	$591.76	$587.24	$533.73	$510.15	$475.49	$416.34	$413.25	$398.47	$391.24
49	$864.60	$669.33	$617.45	$612.74	$556.91	$532.31	$496.14	$434.42	$431.19	$415.77	$408.23
50	$905.14	$700.72	$646.41	$641.48	$583.02	$557.27	$519.40	$454.79	$451.41	$435.27	$427.37
51	$945.18	$731.71	$675.00	$669.85	$608.81	$581.92	$542.38	$474.90	$471.38	$454.52	$446.28
52	$989.27	$765.85	$706.49	$701.10	$637.21	$609.06	$567.68	$497.06	$493.37	$475.72	$467.09
53	$1,033.87	$800.37	$738.34	$732.71	$665.94	$636.52	$593.27	$519.47	$515.61	$497.17	$488.15
54	$1,082.02	$837.65	$772.72	$766.83	$696.95	$666.16	$620.90	$543.66	$539.62	$520.32	$510.88
55	$1,130.16	$874.92	$807.10	$800.95	$727.96	$695.80	$648.53	$567.85	$563.63	$543.47	$533.62
56	$1,182.36	$915.33	$844.38	$837.94	$761.58	$727.94	$678.48	$594.08	$589.67	$568.58	$558.26
57	$1,235.07	$956.13	$882.02	$875.30	$795.53	$760.39	$708.73	$620.56	$615.95	$593.92	$583.15
58	$1,291.33	$999.68	$922.20	$915.17	$831.77	$795.03	$741.01	$648.82	$644.01	$620.97	$609.71
59	$1,319.20	$1,021.26	$942.10	$934.92	$849.72	$812.19	$757.00	$662.83	$657.91	$634.38	$622.87
60	$1,375.46	$1,064.81	$982.28	$974.79	$885.96	$846.82	$789.29	$691.09	$685.96	$661.43	$649.43
61	$1,424.11	$1,102.48	$1,017.02	$1,009.27	$917.30	$876.78	$817.20	$715.54	$710.23	$684.83	$672.40
62	$1,456.04	$1,127.19	$1,039.82	$1,031.90	$937.86	$896.43	$835.53	$731.58	$726.15	$700.18	$687.48
63	$1,496.07	$1,158.19	$1,068.42	$1,060.27	$963.65	$921.08	$858.50	$751.70	$746.12	$719.43	$706.38
64	$1,520.40	$1,177.02	$1,085.79	$1,077.51	$979.32	$936.06	$872.46	$763.92	$758.25	$731.13	$717.87
65 and over	$1,520.40	$1,177.02	$1,085.79	$1,077.51	$979.32	$936.06	$872.46	$763.92	$758.25	$731.13	$717.87

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 2

Rates Effective 6/1/14 through 5/31/15

Region 2 includes the counties of: Marin, Napa, Solano, and Sonoma

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$354.32	$274.29	$269.02	$266.97	$242.64	$231.93	$216.17	$189.27	$187.86	$181.15	$177.86
21	$557.99	$431.96	$423.65	$420.42	$382.11	$365.24	$340.42	$298.07	$295.85	$285.27	$280.10
22	$557.99	$431.96	$423.65	$420.42	$382.11	$365.24	$340.42	$298.07	$295.85	$285.27	$280.10
23	$557.99	$431.96	$423.65	$420.42	$382.11	$365.24	$340.42	$298.07	$295.85	$285.27	$280.10
24	$557.99	$431.96	$423.65	$420.42	$382.11	$365.24	$340.42	$298.07	$295.85	$285.27	$280.10
25	$560.22	$433.69	$425.34	$422.10	$383.64	$366.70	$341.78	$299.26	$297.03	$286.41	$281.22
26	$571.38	$442.33	$433.82	$430.51	$391.28	$374.01	$348.59	$305.22	$302.95	$292.12	$286.82
27	$584.77	$452.69	$443.99	$440.60	$400.45	$382.77	$356.76	$312.38	$310.05	$298.96	$293.54
28	$606.54	$469.54	$460.51	$457.00	$415.35	$397.02	$370.04	$324.00	$321.59	$310.09	$304.47
29	$624.39	$483.36	$474.06	$470.45	$427.58	$408.70	$380.93	$333.54	$331.06	$319.22	$313.43
30	$633.32	$490.27	$480.84	$477.18	$433.69	$414.55	$386.38	$338.31	$335.79	$323.78	$317.91
31	$646.71	$500.64	$491.01	$487.27	$442.87	$423.31	$394.55	$345.46	$342.89	$330.63	$324.64
32	$660.10	$511.01	$501.18	$497.36	$452.04	$432.08	$402.72	$352.62	$349.99	$337.47	$331.36
33	$668.47	$517.49	$507.53	$503.66	$457.77	$437.56	$407.82	$357.09	$354.43	$341.75	$335.56
34	$677.40	$524.40	$514.31	$510.39	$463.88	$443.40	$413.27	$361.86	$359.16	$346.32	$340.04
35	$681.86	$527.86	$517.70	$513.75	$466.94	$446.32	$415.99	$364.24	$361.53	$348.60	$342.28
36	$686.33	$531.31	$521.09	$517.12	$470.00	$449.25	$418.72	$366.63	$363.90	$350.88	$344.52
37	$690.79	$534.77	$524.48	$520.48	$473.05	$452.17	$421.44	$369.01	$366.26	$353.16	$346.76
38	$695.26	$538.22	$527.87	$523.84	$476.11	$455.09	$424.16	$371.40	$368.63	$355.45	$349.00
39	$704.18	$545.13	$534.65	$530.57	$482.22	$460.93	$429.61	$376.16	$373.36	$360.01	$353.49
40	$713.11	$552.04	$541.42	$537.30	$488.34	$466.78	$435.06	$380.93	$378.10	$364.58	$357.97
41	$726.50	$562.41	$551.59	$547.39	$497.51	$475.54	$443.23	$388.09	$385.20	$371.42	$364.69
42	$739.34	$572.35	$561.34	$557.06	$506.30	$483.94	$451.06	$394.94	$392.00	$377.98	$371.13
43	$757.19	$586.17	$574.89	$570.51	$518.52	$495.63	$461.95	$404.48	$401.47	$387.11	$380.10
44	$779.51	$603.45	$591.84	$587.33	$533.81	$510.24	$475.57	$416.40	$413.30	$398.52	$391.30
45	$805.74	$623.75	$611.75	$607.09	$551.77	$527.41	$491.57	$430.41	$427.21	$411.93	$404.46
46	$836.99	$647.94	$635.48	$630.63	$573.17	$547.86	$510.63	$447.11	$443.78	$427.91	$420.15
47	$872.14	$675.15	$662.16	$657.12	$597.24	$570.87	$532.08	$465.88	$462.41	$445.88	$437.80
48	$912.31	$706.25	$692.67	$687.39	$624.75	$597.17	$556.59	$487.34	$483.71	$466.42	$457.96
49	$951.93	$736.92	$722.75	$717.24	$651.88	$623.10	$580.76	$508.51	$504.72	$486.67	$477.85
50	$996.57	$771.48	$756.64	$750.87	$682.45	$652.32	$607.99	$532.35	$528.39	$509.49	$500.26
51	$1,040.65	$805.61	$790.11	$784.08	$712.64	$681.17	$634.88	$555.90	$551.76	$532.03	$522.39
52	$1,089.20	$843.19	$826.96	$820.66	$745.88	$712.95	$664.50	$581.83	$577.50	$556.85	$546.76
53	$1,138.30	$881.20	$864.25	$857.66	$779.50	$745.09	$694.46	$608.06	$603.53	$581.95	$571.40
54	$1,191.31	$922.23	$904.49	$897.60	$815.80	$779.79	$726.80	$636.38	$631.64	$609.05	$598.01
55	$1,244.32	$963.27	$944.74	$937.54	$852.11	$814.49	$759.14	$664.70	$659.75	$636.15	$624.62
56	$1,301.79	$1,007.76	$988.38	$980.84	$891.46	$852.10	$794.20	$695.40	$690.22	$665.53	$653.47
57	$1,359.82	$1,052.69	$1,032.44	$1,024.56	$931.20	$890.09	$829.60	$726.40	$720.99	$695.20	$682.60
58	$1,421.76	$1,100.63	$1,079.46	$1,071.23	$973.62	$930.63	$867.39	$759.48	$753.83	$726.87	$713.69
59	$1,452.45	$1,124.39	$1,102.76	$1,094.35	$994.63	$950.72	$886.11	$775.88	$770.10	$742.56	$729.10
60	$1,514.38	$1,172.34	$1,149.79	$1,141.02	$1,037.05	$991.26	$923.90	$808.96	$802.94	$774.22	$760.19
61	$1,567.95	$1,213.81	$1,190.46	$1,181.38	$1,073.73	$1,026.32	$956.58	$837.58	$831.34	$801.61	$787.08
62	$1,603.11	$1,241.02	$1,217.15	$1,207.87	$1,097.80	$1,049.33	$978.03	$856.36	$849.98	$819.58	$804.73
63	$1,647.19	$1,275.15	$1,250.61	$1,241.08	$1,127.99	$1,078.19	$1,004.92	$879.90	$873.35	$842.12	$826.86
64	$1,673.97	$1,295.88	$1,270.95	$1,261.26	$1,146.33	$1,095.72	$1,021.26	$894.21	$887.55	$855.81	$840.30
65 and over	$1,673.97	$1,295.88	$1,270.95	$1,261.26	$1,146.33	$1,095.72	$1,021.26	$894.21	$887.55	$855.81	$840.30

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 3

Rates Effective 6/1/14 through 5/31/15

Region 3 includes the counties of: El Dorado, Placer, Sacramento, and Yolo

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$326.01	$252.37	$273.27	$271.19	$246.48	$235.59	$219.59	$192.27	$190.84	$184.01	$180.68
21	$513.40	$397.44	$430.35	$427.07	$388.16	$371.01	$345.81	$302.78	$300.53	$289.78	$284.53
22	$513.40	$397.44	$430.35	$427.07	$388.16	$371.01	$345.81	$302.78	$300.53	$289.78	$284.53
23	$513.40	$397.44	$430.35	$427.07	$388.16	$371.01	$345.81	$302.78	$300.53	$289.78	$284.53
24	$513.40	$397.44	$430.35	$427.07	$388.16	$371.01	$345.81	$302.78	$300.53	$289.78	$284.53
25	$515.45	$399.03	$432.07	$428.78	$389.71	$372.49	$347.19	$303.99	$301.73	$290.94	$285.67
26	$525.72	$406.98	$440.68	$437.32	$397.48	$379.91	$354.11	$310.05	$307.74	$296.73	$291.36
27	$538.04	$416.52	$451.01	$447.57	$406.79	$388.82	$362.41	$317.31	$314.96	$303.69	$298.19
28	$558.07	$432.02	$467.79	$464.23	$421.93	$403.29	$375.90	$329.12	$326.68	$314.99	$309.28
29	$574.49	$444.74	$481.56	$477.89	$434.35	$415.16	$386.96	$338.81	$336.29	$324.26	$318.39
30	$582.71	$451.09	$488.45	$484.72	$440.56	$421.10	$392.49	$343.66	$341.10	$328.90	$322.94
31	$595.03	$460.63	$498.78	$494.97	$449.88	$430.00	$400.79	$350.92	$348.31	$335.86	$329.77
32	$607.35	$470.17	$509.10	$505.22	$459.19	$438.90	$409.09	$358.19	$355.53	$342.81	$336.60
33	$615.05	$476.13	$515.56	$511.63	$465.02	$444.47	$414.28	$362.73	$360.03	$347.16	$340.87
34	$623.27	$482.49	$522.44	$518.46	$471.23	$450.41	$419.81	$367.57	$364.84	$351.79	$345.42
35	$627.37	$485.67	$525.89	$521.88	$474.33	$453.37	$422.58	$370.00	$367.25	$354.11	$347.70
36	$631.48	$488.85	$529.33	$525.30	$477.44	$456.34	$425.35	$372.42	$369.65	$356.43	$349.97
37	$635.59	$492.03	$532.77	$528.71	$480.54	$459.31	$428.11	$374.84	$372.06	$358.75	$352.25
38	$639.70	$495.21	$536.22	$532.13	$483.65	$462.28	$430.88	$377.26	$374.46	$361.07	$354.52
39	$647.91	$501.57	$543.10	$538.96	$489.86	$468.21	$436.41	$382.11	$379.27	$365.70	$359.08
40	$656.13	$507.93	$549.99	$545.80	$496.07	$474.15	$441.95	$386.95	$384.08	$370.34	$363.63
41	$668.45	$517.47	$560.32	$556.05	$505.38	$483.06	$450.24	$394.22	$391.29	$377.29	$370.46
42	$680.26	$526.61	$570.21	$565.87	$514.31	$491.59	$458.20	$401.18	$398.20	$383.96	$377.00
43	$696.68	$539.33	$583.98	$579.53	$526.73	$503.46	$469.26	$410.87	$407.82	$393.23	$386.11
44	$717.22	$555.22	$601.20	$596.62	$542.26	$518.30	$483.10	$422.98	$419.84	$404.82	$397.49
45	$741.35	$573.90	$621.43	$616.69	$560.50	$535.74	$499.35	$437.21	$433.97	$418.44	$410.86
46	$770.10	$596.16	$645.53	$640.61	$582.24	$556.52	$518.72	$454.17	$450.80	$434.67	$426.80
47	$802.44	$621.20	$672.64	$667.51	$606.69	$579.89	$540.50	$473.25	$469.73	$452.93	$444.72
48	$839.41	$649.81	$703.62	$698.26	$634.64	$606.60	$565.40	$495.05	$491.37	$473.79	$465.21
49	$875.86	$678.03	$734.18	$728.58	$662.20	$632.94	$589.95	$516.54	$512.70	$494.36	$485.41
50	$916.93	$709.83	$768.61	$762.75	$693.25	$662.62	$617.62	$540.77	$536.75	$517.55	$508.17
51	$957.49	$741.23	$802.60	$796.49	$723.92	$691.93	$644.94	$564.68	$560.49	$540.44	$530.65
52	$1,002.16	$775.80	$840.04	$833.64	$757.69	$724.21	$675.02	$591.03	$586.63	$565.65	$555.40
53	$1,047.34	$810.78	$877.91	$871.22	$791.85	$756.86	$705.45	$617.67	$613.08	$591.15	$580.44
54	$1,096.11	$848.53	$918.80	$911.79	$828.72	$792.11	$738.30	$646.44	$641.63	$618.68	$607.47
55	$1,144.88	$886.29	$959.68	$952.37	$865.60	$827.35	$771.16	$675.20	$670.18	$646.21	$634.50
56	$1,197.76	$927.23	$1,004.01	$996.35	$905.58	$865.57	$806.77	$706.39	$701.14	$676.06	$663.81
57	$1,251.16	$968.56	$1,048.76	$1,040.77	$945.95	$904.15	$842.74	$737.87	$732.39	$706.19	$693.40
58	$1,308.14	$1,012.68	$1,096.53	$1,088.17	$989.03	$945.33	$881.12	$771.48	$765.75	$738.36	$724.98
59	$1,336.38	$1,034.54	$1,120.20	$1,111.66	$1,010.38	$965.74	$900.14	$788.14	$782.28	$754.30	$740.63
60	$1,393.37	$1,078.65	$1,167.97	$1,159.07	$1,053.47	$1,006.92	$938.53	$821.74	$815.64	$786.46	$772.21
61	$1,442.65	$1,116.81	$1,209.28	$1,200.07	$1,090.73	$1,042.54	$971.73	$850.81	$844.49	$814.28	$799.53
62	$1,475.00	$1,141.85	$1,236.40	$1,226.97	$1,115.18	$1,065.91	$993.51	$869.89	$863.42	$832.54	$817.45
63	$1,515.56	$1,173.24	$1,270.39	$1,260.71	$1,145.85	$1,095.22	$1,020.83	$893.81	$887.16	$855.43	$839.93
64	$1,540.20	$1,192.32	$1,291.05	$1,281.21	$1,164.48	$1,113.03	$1,037.43	$908.34	$901.59	$869.34	$853.59
65 and over	$1,540.20	$1,192.32	$1,291.05	$1,281.21	$1,164.48	$1,113.03	$1,037.43	$908.34	$901.59	$869.34	$853.59

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 4

Rates Effective 6/1/14 through 5/31/15

Region 4 includes the county of: San Francisco

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$318.55	$246.60	$299.04	$296.76	$269.72	$257.80	$240.29	$210.39	$208.83	$201.36	$197.71
21	$501.65	$388.35	$470.93	$467.34	$424.76	$405.99	$378.41	$331.33	$328.87	$317.11	$311.36
22	$501.65	$388.35	$470.93	$467.34	$424.76	$405.99	$378.41	$331.33	$328.87	$317.11	$311.36
23	$501.65	$388.35	$470.93	$467.34	$424.76	$405.99	$378.41	$331.33	$328.87	$317.11	$311.36
24	$501.65	$388.35	$470.93	$467.34	$424.76	$405.99	$378.41	$331.33	$328.87	$317.11	$311.36
25	$503.66	$389.90	$472.81	$469.21	$426.46	$407.61	$379.92	$332.66	$330.19	$318.38	$312.61
26	$513.69	$397.67	$482.23	$478.56	$434.95	$415.73	$387.49	$339.28	$336.76	$324.72	$318.83
27	$525.73	$406.99	$493.53	$489.77	$445.15	$425.48	$396.57	$347.23	$344.66	$332.33	$326.31
28	$545.29	$422.14	$511.90	$508.00	$461.71	$441.31	$411.33	$360.16	$357.48	$344.70	$338.45
29	$561.35	$434.56	$526.97	$522.95	$475.31	$454.30	$423.44	$370.76	$368.01	$354.85	$348.41
30	$569.37	$440.78	$534.51	$530.43	$482.10	$460.80	$429.50	$376.06	$373.27	$359.92	$353.39
31	$581.41	$450.10	$545.81	$541.65	$492.30	$470.54	$438.58	$384.01	$381.16	$367.53	$360.87
32	$593.45	$459.42	$557.11	$552.86	$502.49	$480.29	$447.66	$391.96	$389.05	$375.14	$368.34
33	$600.98	$465.24	$564.17	$559.87	$508.86	$486.38	$453.34	$396.93	$393.99	$379.90	$373.01
34	$609.00	$471.46	$571.71	$567.35	$515.66	$492.87	$459.39	$402.23	$399.25	$384.97	$377.99
35	$613.02	$474.56	$575.48	$571.09	$519.06	$496.12	$462.42	$404.89	$401.88	$387.51	$380.48
36	$617.03	$477.67	$579.24	$574.83	$522.45	$499.37	$465.44	$407.54	$404.51	$390.05	$382.97
37	$621.04	$480.78	$583.01	$578.57	$525.85	$502.62	$468.47	$410.19	$407.14	$392.58	$385.46
38	$625.06	$483.88	$586.78	$582.31	$529.25	$505.86	$471.50	$412.84	$409.77	$395.12	$387.95
39	$633.08	$490.10	$594.31	$589.78	$536.05	$512.36	$477.55	$418.14	$415.03	$400.19	$392.94
40	$641.11	$496.31	$601.85	$597.26	$542.84	$518.86	$483.61	$423.44	$420.30	$405.27	$397.92
41	$653.15	$505.63	$613.15	$608.48	$553.04	$528.60	$492.69	$431.39	$428.19	$412.88	$405.39
42	$664.69	$514.56	$623.98	$619.23	$562.81	$537.94	$501.39	$439.01	$435.75	$420.17	$412.55
43	$680.74	$526.99	$639.05	$634.18	$576.40	$550.93	$513.50	$449.61	$446.28	$430.32	$422.52
44	$700.81	$542.52	$657.89	$652.87	$593.39	$567.17	$528.64	$462.87	$459.43	$443.00	$434.97
45	$724.38	$560.78	$680.02	$674.84	$613.35	$586.25	$546.42	$478.44	$474.89	$457.91	$449.60
46	$752.48	$582.53	$706.40	$701.01	$637.14	$608.99	$567.62	$497.00	$493.31	$475.67	$467.04
47	$784.08	$606.99	$736.06	$730.45	$663.90	$634.56	$591.45	$517.87	$514.02	$495.64	$486.66
48	$820.20	$634.95	$769.97	$764.10	$694.48	$663.79	$618.70	$541.72	$537.70	$518.47	$509.07
49	$855.81	$662.53	$803.41	$797.28	$724.64	$692.62	$645.57	$565.25	$561.05	$540.99	$531.18
50	$895.95	$693.59	$841.08	$834.67	$758.62	$725.10	$675.84	$591.76	$587.36	$566.36	$556.09
51	$935.58	$724.27	$878.28	$871.59	$792.18	$757.17	$705.73	$617.93	$613.34	$591.41	$580.69
52	$979.22	$758.06	$919.26	$912.25	$829.13	$792.49	$738.66	$646.76	$641.95	$619.00	$607.77
53	$1,023.37	$792.23	$960.70	$953.37	$866.51	$828.22	$771.96	$675.91	$670.89	$646.90	$635.17
54	$1,071.02	$829.13	$1,005.44	$997.77	$906.86	$866.79	$807.91	$707.39	$702.14	$677.03	$664.75
55	$1,118.68	$866.02	$1,050.17	$1,042.17	$947.21	$905.36	$843.85	$738.87	$733.38	$707.16	$694.33
56	$1,170.35	$906.02	$1,098.68	$1,090.30	$990.97	$947.17	$882.83	$772.99	$767.25	$739.82	$726.40
57	$1,222.52	$946.41	$1,147.66	$1,138.91	$1,035.14	$989.40	$922.19	$807.45	$801.46	$772.80	$758.78
58	$1,278.20	$989.52	$1,199.93	$1,190.78	$1,082.29	$1,034.46	$964.19	$844.23	$837.96	$808.00	$793.35
59	$1,305.79	$1,010.88	$1,225.83	$1,216.49	$1,105.65	$1,056.79	$985.00	$862.45	$856.05	$825.44	$810.47
60	$1,361.48	$1,053.98	$1,278.10	$1,268.36	$1,152.80	$1,101.86	$1,027.00	$899.23	$892.55	$860.64	$845.03
61	$1,409.64	$1,091.26	$1,323.31	$1,313.23	$1,193.58	$1,140.83	$1,063.33	$931.04	$924.12	$891.08	$874.92
62	$1,441.24	$1,115.73	$1,352.98	$1,342.67	$1,220.34	$1,166.41	$1,087.17	$951.91	$944.84	$911.06	$894.54
63	$1,480.87	$1,146.41	$1,390.19	$1,379.59	$1,253.89	$1,198.48	$1,117.07	$978.09	$970.82	$936.11	$919.13
64	$1,504.95	$1,165.05	$1,412.79	$1,402.02	$1,274.28	$1,217.97	$1,135.23	$993.99	$986.61	$951.33	$934.08
65 and over	$1,504.95	$1,165.05	$1,412.79	$1,402.02	$1,274.28	$1,217.97	$1,135.23	$993.99	$986.61	$951.33	$934.08

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 5

Rates Effective 6/1/14 through 5/31/15

Region 5 includes the county of: Contra Costa

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$318.55	$246.60	$279.31	$277.18	$251.92	$240.80	$224.44	$196.51	$195.05	$188.08	$184.67
21	$501.65	$388.35	$439.86	$436.51	$396.73	$379.21	$353.45	$309.47	$307.17	$296.19	$290.82
22	$501.65	$388.35	$439.86	$436.51	$396.73	$379.21	$353.45	$309.47	$307.17	$296.19	$290.82
23	$501.65	$388.35	$439.86	$436.51	$396.73	$379.21	$353.45	$309.47	$307.17	$296.19	$290.82
24	$501.65	$388.35	$439.86	$436.51	$396.73	$379.21	$353.45	$309.47	$307.17	$296.19	$290.82
25	$503.66	$389.90	$441.62	$438.26	$398.32	$380.73	$354.86	$310.71	$308.40	$297.37	$291.98
26	$513.69	$397.67	$450.42	$446.99	$406.25	$388.31	$361.93	$316.90	$314.54	$303.30	$297.80
27	$525.73	$406.99	$460.97	$457.46	$415.77	$397.41	$370.42	$324.32	$321.91	$310.41	$304.78
28	$545.29	$422.14	$478.13	$474.49	$431.25	$412.20	$384.20	$336.39	$333.89	$321.96	$316.12
29	$561.35	$434.56	$492.20	$488.45	$443.94	$424.34	$395.51	$346.30	$343.72	$331.44	$325.43
30	$569.37	$440.78	$499.24	$495.44	$450.29	$430.40	$401.17	$351.25	$348.64	$336.18	$330.08
31	$581.41	$450.10	$509.80	$505.92	$459.81	$439.50	$409.65	$358.68	$356.01	$343.28	$337.06
32	$593.45	$459.42	$520.35	$516.39	$469.33	$448.61	$418.13	$366.10	$363.38	$350.39	$344.04
33	$600.98	$465.24	$526.95	$522.94	$475.28	$454.29	$423.43	$370.75	$367.99	$354.84	$348.40
34	$609.00	$471.46	$533.99	$529.92	$481.63	$460.36	$429.09	$375.70	$372.90	$359.57	$353.06
35	$613.02	$474.56	$537.51	$533.42	$484.80	$463.39	$431.92	$378.17	$375.36	$361.94	$355.38
36	$617.03	$477.67	$541.03	$536.91	$487.98	$466.43	$434.74	$380.65	$377.82	$364.31	$357.71
37	$621.04	$480.78	$544.55	$540.40	$491.15	$469.46	$437.57	$383.12	$380.28	$366.68	$360.04
38	$625.06	$483.88	$548.07	$543.89	$494.33	$472.50	$440.40	$385.60	$382.73	$369.05	$362.36
39	$633.08	$490.10	$555.10	$550.88	$500.67	$478.56	$446.05	$390.55	$387.65	$373.79	$367.01
40	$641.11	$496.31	$562.14	$557.86	$507.02	$484.63	$451.71	$395.50	$392.56	$378.53	$371.67
41	$653.15	$505.63	$572.70	$568.34	$516.54	$493.73	$460.19	$402.93	$399.94	$385.64	$378.65
42	$664.69	$514.56	$582.81	$578.38	$525.67	$502.45	$468.32	$410.05	$407.00	$392.45	$385.34
43	$680.74	$526.99	$596.89	$592.34	$538.36	$514.59	$479.63	$419.95	$416.83	$401.93	$394.64
44	$700.81	$542.52	$614.48	$609.80	$554.23	$529.76	$493.77	$432.33	$429.12	$413.78	$406.28
45	$724.38	$560.78	$635.16	$630.32	$572.88	$547.58	$510.38	$446.87	$443.55	$427.70	$419.94
46	$752.48	$582.53	$659.79	$654.77	$595.10	$568.82	$530.18	$464.21	$460.76	$444.29	$436.23
47	$784.08	$606.99	$687.50	$682.27	$620.09	$592.71	$552.44	$483.70	$480.11	$462.94	$454.55
48	$820.20	$634.95	$719.17	$713.69	$648.65	$620.01	$577.89	$505.98	$502.22	$484.27	$475.49
49	$855.81	$662.53	$750.40	$744.69	$676.82	$646.93	$602.99	$527.96	$524.03	$505.30	$496.14
50	$895.95	$693.59	$785.59	$779.61	$708.56	$677.27	$631.26	$552.71	$548.61	$529.00	$519.40
51	$935.58	$724.27	$820.34	$814.09	$739.90	$707.23	$659.18	$577.16	$572.87	$552.39	$542.38
52	$979.22	$758.06	$858.61	$852.07	$774.42	$740.22	$689.93	$604.09	$599.60	$578.16	$567.68
53	$1,023.37	$792.23	$897.31	$890.48	$809.33	$773.59	$721.04	$631.32	$626.63	$604.23	$593.27
54	$1,071.02	$829.13	$939.10	$931.95	$847.02	$809.61	$754.62	$660.72	$655.81	$632.37	$620.90
55	$1,118.68	$866.02	$980.89	$973.42	$884.71	$845.64	$788.19	$690.12	$684.99	$660.50	$648.53
56	$1,170.35	$906.02	$1,026.19	$1,018.38	$925.57	$884.70	$824.60	$721.99	$716.63	$691.01	$678.48
57	$1,222.52	$946.41	$1,071.94	$1,063.77	$966.83	$924.13	$861.36	$754.18	$748.57	$721.82	$708.73
58	$1,278.20	$989.52	$1,120.76	$1,112.23	$1,010.87	$966.23	$900.59	$788.53	$782.67	$754.69	$741.01
59	$1,305.79	$1,010.88	$1,144.96	$1,136.24	$1,032.69	$987.08	$920.03	$805.55	$799.56	$770.98	$757.00
60	$1,361.48	$1,053.98	$1,193.78	$1,184.69	$1,076.73	$1,029.18	$959.26	$839.90	$833.66	$803.86	$789.29
61	$1,409.64	$1,091.26	$1,236.01	$1,226.59	$1,114.81	$1,065.58	$993.19	$869.61	$863.15	$832.29	$817.20
62	$1,441.24	$1,115.73	$1,263.72	$1,254.09	$1,139.81	$1,089.47	$1,015.46	$889.11	$882.50	$850.95	$835.53
63	$1,480.87	$1,146.41	$1,298.47	$1,288.58	$1,171.15	$1,119.43	$1,043.38	$913.56	$906.77	$874.35	$858.50
64	$1,504.95	$1,165.05	$1,319.58	$1,309.53	$1,190.19	$1,137.63	$1,060.35	$928.41	$921.51	$888.57	$872.46
65 and over	$1,504.95	$1,165.05	$1,319.58	$1,309.53	$1,190.19	$1,137.63	$1,060.35	$928.41	$921.51	$888.57	$872.46

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 6

Rates Effective 6/1/14 through 5/31/15

Region 6 includes the couny of: Alameda

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$318.55	$246.60	$282.02	$279.87	$254.37	$243.14	$226.61	$198.42	$196.95	$189.90	$186.46
21	$501.65	$388.35	$444.13	$440.74	$400.58	$382.89	$356.87	$312.47	$310.15	$299.06	$293.64
22	$501.65	$388.35	$444.13	$440.74	$400.58	$382.89	$356.87	$312.47	$310.15	$299.06	$293.64
23	$501.65	$388.35	$444.13	$440.74	$400.58	$382.89	$356.87	$312.47	$310.15	$299.06	$293.64
24	$501.65	$388.35	$444.13	$440.74	$400.58	$382.89	$356.87	$312.47	$310.15	$299.06	$293.64
25	$503.66	$389.90	$445.91	$442.50	$402.18	$384.42	$358.30	$313.72	$311.39	$300.26	$294.81
26	$513.69	$397.67	$454.79	$451.32	$410.19	$392.08	$365.43	$319.97	$317.59	$306.24	$300.69
27	$525.73	$406.99	$465.45	$461.90	$419.81	$401.27	$374.00	$327.47	$325.04	$313.41	$307.73
28	$545.29	$422.14	$482.77	$479.08	$435.43	$416.20	$387.92	$339.65	$337.13	$325.08	$319.19
29	$561.35	$434.56	$496.98	$493.19	$448.25	$428.45	$399.34	$349.65	$347.06	$334.65	$328.58
30	$569.37	$440.78	$504.09	$500.24	$454.66	$434.58	$405.05	$354.65	$352.02	$339.43	$333.28
31	$581.41	$450.10	$514.75	$510.82	$464.27	$443.77	$413.61	$362.15	$359.46	$346.61	$340.33
32	$593.45	$459.42	$525.41	$521.40	$473.89	$452.96	$422.18	$369.65	$366.91	$353.79	$347.38
33	$600.98	$465.24	$532.07	$528.01	$479.89	$458.70	$427.53	$374.34	$371.56	$358.27	$351.78
34	$609.00	$471.46	$539.17	$535.06	$486.30	$464.83	$433.24	$379.34	$376.52	$363.06	$356.48
35	$613.02	$474.56	$542.73	$538.58	$489.51	$467.89	$436.10	$381.84	$379.00	$365.45	$358.83
36	$617.03	$477.67	$546.28	$542.11	$492.71	$470.95	$438.95	$384.34	$381.48	$367.84	$361.18
37	$621.04	$480.78	$549.83	$545.64	$495.92	$474.02	$441.81	$386.84	$383.97	$370.24	$363.53
38	$625.06	$483.88	$553.39	$549.16	$499.12	$477.08	$444.66	$389.34	$386.45	$372.63	$365.88
39	$633.08	$490.10	$560.49	$556.21	$505.53	$483.21	$450.37	$394.34	$391.41	$377.41	$370.57
40	$641.11	$496.31	$567.60	$563.27	$511.94	$489.33	$456.08	$399.34	$396.37	$382.20	$375.27
41	$653.15	$505.63	$578.26	$573.84	$521.56	$498.52	$464.64	$406.84	$403.82	$389.38	$382.32
42	$664.69	$514.56	$588.47	$583.98	$530.77	$507.33	$472.85	$414.02	$410.95	$396.25	$389.07
43	$680.74	$526.99	$602.68	$598.08	$543.59	$519.58	$484.27	$424.02	$420.87	$405.82	$398.47
44	$700.81	$542.52	$620.45	$615.71	$559.61	$534.90	$498.55	$436.52	$433.28	$417.79	$410.22
45	$724.38	$560.78	$641.32	$636.43	$578.44	$552.89	$515.32	$451.21	$447.86	$431.84	$424.02
46	$752.48	$582.53	$666.20	$661.11	$600.87	$574.34	$535.31	$468.71	$465.23	$448.59	$440.46
47	$784.08	$606.99	$694.18	$688.88	$626.11	$598.46	$557.79	$488.39	$484.76	$467.43	$458.96
48	$820.20	$634.95	$726.15	$720.61	$654.95	$626.03	$583.48	$510.89	$507.10	$488.96	$480.10
49	$855.81	$662.53	$757.69	$751.90	$683.39	$653.21	$608.82	$533.07	$529.12	$510.20	$500.95
50	$895.95	$693.59	$793.22	$787.16	$715.44	$683.84	$637.37	$558.07	$553.93	$534.12	$524.44
51	$935.58	$724.27	$828.30	$821.98	$747.08	$714.09	$665.56	$582.76	$578.43	$557.75	$547.64
52	$979.22	$758.06	$866.94	$860.32	$781.93	$747.40	$696.61	$609.94	$605.41	$583.77	$573.19
53	$1,023.37	$792.23	$906.03	$899.11	$817.18	$781.10	$728.01	$637.44	$632.71	$610.08	$599.03
54	$1,071.02	$829.13	$948.22	$940.98	$855.24	$817.47	$761.92	$667.12	$662.17	$638.49	$626.92
55	$1,118.68	$866.02	$990.41	$982.85	$893.29	$853.84	$795.82	$696.81	$691.63	$666.90	$654.82
56	$1,170.35	$906.02	$1,036.16	$1,028.25	$934.55	$893.28	$832.58	$728.99	$723.58	$697.71	$685.06
57	$1,222.52	$946.41	$1,082.34	$1,074.08	$976.21	$933.10	$869.69	$761.49	$755.84	$728.81	$715.60
58	$1,278.20	$989.52	$1,131.64	$1,123.01	$1,020.68	$975.60	$909.30	$796.17	$790.26	$762.00	$748.19
59	$1,305.79	$1,010.88	$1,156.07	$1,147.25	$1,042.71	$996.66	$928.93	$813.36	$807.32	$778.45	$764.34
60	$1,361.48	$1,053.98	$1,205.37	$1,196.17	$1,087.17	$1,039.16	$968.55	$848.04	$841.75	$811.65	$796.94
61	$1,409.64	$1,091.26	$1,248.01	$1,238.48	$1,125.63	$1,075.92	$1,002.80	$878.04	$871.52	$840.36	$825.13
62	$1,441.24	$1,115.73	$1,275.99	$1,266.25	$1,150.87	$1,100.04	$1,025.29	$897.73	$891.06	$859.20	$843.63
63	$1,480.87	$1,146.41	$1,311.07	$1,301.06	$1,182.51	$1,130.29	$1,053.48	$922.41	$915.56	$882.83	$866.83
64	$1,504.95	$1,165.05	$1,332.39	$1,322.22	$1,201.74	$1,148.67	$1,070.61	$937.41	$930.45	$897.18	$880.92
65 and over	$1,504.95	$1,165.05	$1,332.39	$1,322.22	$1,201.74	$1,148.67	$1,070.61	$937.41	$930.45	$897.18	$880.92

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 7

Rates Effective 6/1/14 through 5/31/15

Region 7 includes the county of: Santa Clara

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$318.55	$246.60	$266.17	$264.14	$240.07	$229.46	$213.87	$187.27	$185.87	$179.23	$175.98
21	$501.65	$388.35	$419.16	$415.97	$378.06	$361.36	$336.81	$294.91	$292.71	$282.25	$277.13
22	$501.65	$388.35	$419.16	$415.97	$378.06	$361.36	$336.81	$294.91	$292.71	$282.25	$277.13
23	$501.65	$388.35	$419.16	$415.97	$378.06	$361.36	$336.81	$294.91	$292.71	$282.25	$277.13
24	$501.65	$388.35	$419.16	$415.97	$378.06	$361.36	$336.81	$294.91	$292.71	$282.25	$277.13
25	$503.66	$389.90	$420.84	$417.63	$379.57	$362.81	$338.16	$296.09	$293.88	$283.38	$278.24
26	$513.69	$397.67	$429.22	$425.95	$387.13	$370.03	$344.89	$301.99	$299.74	$289.02	$283.78
27	$525.73	$406.99	$439.28	$435.94	$396.21	$378.71	$352.98	$309.07	$306.76	$295.80	$290.43
28	$545.29	$422.14	$455.63	$452.16	$410.95	$392.80	$366.11	$320.57	$318.18	$306.81	$301.24
29	$561.35	$434.56	$469.04	$465.47	$423.05	$404.36	$376.89	$330.00	$327.54	$315.84	$310.11
30	$569.37	$440.78	$475.75	$472.13	$429.10	$410.14	$382.28	$334.72	$332.23	$320.35	$314.54
31	$581.41	$450.10	$485.81	$482.11	$438.17	$418.82	$390.36	$341.80	$339.25	$327.13	$321.19
32	$593.45	$459.42	$495.87	$492.09	$447.24	$427.49	$398.45	$348.88	$346.28	$333.90	$327.84
33	$600.98	$465.24	$502.15	$498.33	$452.92	$432.91	$403.50	$353.30	$350.67	$338.14	$332.00
34	$609.00	$471.46	$508.86	$504.99	$458.96	$438.69	$408.89	$358.02	$355.35	$342.65	$336.44
35	$613.02	$474.56	$512.21	$508.32	$461.99	$441.58	$411.58	$360.38	$357.69	$344.91	$338.65
36	$617.03	$477.67	$515.57	$511.64	$465.01	$444.47	$414.28	$362.74	$360.03	$347.17	$340.87
37	$621.04	$480.78	$518.92	$514.97	$468.04	$447.36	$416.97	$365.10	$362.37	$349.43	$343.09
38	$625.06	$483.88	$522.27	$518.30	$471.06	$450.25	$419.67	$367.46	$364.72	$351.68	$345.30
39	$633.08	$490.10	$528.98	$524.95	$477.11	$456.04	$425.05	$372.18	$369.40	$356.20	$349.74
40	$641.11	$496.31	$535.69	$531.61	$483.16	$461.82	$430.44	$376.89	$374.08	$360.72	$354.17
41	$653.15	$505.63	$545.75	$541.59	$492.23	$470.49	$438.53	$383.97	$381.11	$367.49	$360.82
42	$664.69	$514.56	$555.39	$551.16	$500.93	$478.80	$446.27	$390.76	$387.84	$373.98	$367.20
43	$680.74	$526.99	$568.80	$564.47	$513.03	$490.37	$457.05	$400.19	$397.21	$383.01	$376.07
44	$700.81	$542.52	$585.57	$581.11	$528.15	$504.82	$470.52	$411.99	$408.92	$394.30	$387.15
45	$724.38	$560.78	$605.27	$600.66	$545.92	$521.80	$486.35	$425.85	$422.67	$407.57	$400.18
46	$752.48	$582.53	$628.74	$623.96	$567.09	$542.04	$505.22	$442.37	$439.07	$423.38	$415.70
47	$784.08	$606.99	$655.15	$650.16	$590.91	$564.81	$526.43	$460.94	$457.51	$441.16	$433.15
48	$820.20	$634.95	$685.33	$680.11	$618.13	$590.82	$550.68	$482.18	$478.58	$461.48	$453.11
49	$855.81	$662.53	$715.09	$709.64	$644.97	$616.48	$574.60	$503.12	$499.36	$481.52	$472.78
50	$895.95	$693.59	$748.62	$742.92	$675.22	$645.39	$601.54	$526.71	$522.78	$504.10	$494.95
51	$935.58	$724.27	$781.73	$775.78	$705.08	$673.94	$628.15	$550.01	$545.90	$526.40	$516.85
52	$979.22	$758.06	$818.20	$811.97	$737.97	$705.37	$657.45	$575.66	$571.37	$550.95	$540.96
53	$1,023.37	$792.23	$855.09	$848.58	$771.24	$737.17	$687.09	$601.62	$597.13	$575.79	$565.35
54	$1,071.02	$829.13	$894.91	$888.10	$807.16	$771.50	$719.09	$629.63	$624.94	$602.60	$591.67
55	$1,118.68	$866.02	$934.73	$927.61	$843.07	$805.83	$751.09	$657.65	$652.74	$629.42	$618.00
56	$1,170.35	$906.02	$977.90	$970.46	$882.01	$843.05	$785.78	$688.03	$682.89	$658.49	$646.54
57	$1,222.52	$946.41	$1,021.49	$1,013.72	$921.33	$880.63	$820.81	$718.70	$713.33	$687.84	$675.37
58	$1,278.20	$989.52	$1,068.02	$1,059.89	$963.30	$920.75	$858.19	$751.43	$745.83	$719.17	$706.13
59	$1,305.79	$1,010.88	$1,091.07	$1,082.77	$984.09	$940.62	$876.72	$767.65	$761.92	$734.70	$721.37
60	$1,361.48	$1,053.98	$1,137.60	$1,128.94	$1,026.05	$980.73	$914.10	$800.39	$794.41	$766.03	$752.13
61	$1,409.64	$1,091.26	$1,177.84	$1,168.88	$1,062.35	$1,015.42	$946.44	$828.70	$822.52	$793.12	$778.74
62	$1,441.24	$1,115.73	$1,204.25	$1,195.08	$1,086.17	$1,038.19	$967.66	$847.28	$840.96	$810.90	$796.19
63	$1,480.87	$1,146.41	$1,237.36	$1,227.94	$1,116.03	$1,066.73	$994.26	$870.57	$864.08	$833.20	$818.09
64	$1,504.95	$1,165.05	$1,257.48	$1,247.91	$1,134.18	$1,084.08	$1,010.43	$884.73	$878.13	$846.75	$831.39
65 and over	$1,504.95	$1,165.05	$1,257.48	$1,247.91	$1,134.18	$1,084.08	$1,010.43	$884.73	$878.13	$846.75	$831.39

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Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 8

Rates Effective 6/1/14 through 5/31/15

Region 8 includes the county of: San Mateo

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$359.41	$278.24	$309.42	$307.07	$279.09	$266.76	$248.63	$217.70	$216.08	$208.36	$204.58
21	$566.00	$438.17	$487.28	$483.57	$439.51	$420.09	$391.55	$342.84	$340.29	$328.12	$322.17
22	$566.00	$438.17	$487.28	$483.57	$439.51	$420.09	$391.55	$342.84	$340.29	$328.12	$322.17
23	$566.00	$438.17	$487.28	$483.57	$439.51	$420.09	$391.55	$342.84	$340.29	$328.12	$322.17
24	$566.00	$438.17	$487.28	$483.57	$439.51	$420.09	$391.55	$342.84	$340.29	$328.12	$322.17
25	$568.26	$439.92	$489.23	$485.50	$441.27	$421.77	$393.12	$344.21	$341.65	$329.43	$323.46
26	$579.58	$448.69	$498.97	$495.18	$450.06	$430.17	$400.95	$351.07	$348.46	$335.99	$329.90
27	$593.17	$459.20	$510.67	$506.78	$460.61	$440.25	$410.34	$359.30	$356.62	$343.87	$337.63
28	$615.24	$476.29	$529.67	$525.64	$477.75	$456.64	$425.61	$372.67	$369.90	$356.67	$350.20
29	$633.35	$490.31	$545.27	$541.11	$491.81	$470.08	$438.14	$383.64	$380.78	$367.17	$360.51
30	$642.41	$497.32	$553.06	$548.85	$498.84	$476.80	$444.41	$389.12	$386.23	$372.42	$365.66
31	$655.99	$507.84	$564.76	$560.46	$509.39	$486.88	$453.81	$397.35	$394.40	$380.29	$373.40
32	$669.58	$518.36	$576.45	$572.06	$519.94	$496.97	$463.20	$405.58	$402.56	$388.17	$381.13
33	$678.07	$524.93	$583.76	$579.32	$526.53	$503.27	$469.08	$410.72	$407.67	$393.09	$385.96
34	$687.12	$531.94	$591.56	$587.05	$533.57	$509.99	$475.34	$416.21	$413.11	$398.34	$391.11
35	$691.65	$535.44	$595.46	$590.92	$537.08	$513.35	$478.47	$418.95	$415.83	$400.96	$393.69
36	$696.18	$538.95	$599.35	$594.79	$540.60	$516.71	$481.61	$421.69	$418.56	$403.59	$396.27
37	$700.71	$542.45	$603.25	$598.66	$544.11	$520.07	$484.74	$424.44	$421.28	$406.21	$398.85
38	$705.24	$545.96	$607.15	$602.53	$547.63	$523.43	$487.87	$427.18	$424.00	$408.84	$401.42
39	$714.29	$552.97	$614.95	$610.27	$554.66	$530.15	$494.14	$432.66	$429.45	$414.09	$406.58
40	$723.35	$559.98	$622.74	$618.00	$561.69	$536.88	$500.40	$438.15	$434.89	$419.34	$411.73
41	$736.93	$570.50	$634.44	$629.61	$572.24	$546.96	$509.80	$446.38	$443.06	$427.21	$419.47
42	$749.95	$580.58	$645.65	$640.73	$582.35	$556.62	$518.80	$454.26	$450.88	$434.76	$426.88
43	$768.06	$594.60	$661.24	$656.20	$596.42	$570.06	$531.33	$465.23	$461.77	$445.26	$437.18
44	$790.70	$612.12	$680.73	$675.55	$614.00	$586.87	$547.00	$478.95	$475.39	$458.38	$450.07
45	$817.30	$632.72	$703.63	$698.28	$634.65	$606.61	$565.40	$495.06	$491.38	$473.81	$465.21
46	$849.00	$657.26	$730.92	$725.36	$659.27	$630.14	$587.33	$514.26	$510.44	$492.18	$483.26
47	$884.66	$684.86	$761.62	$755.82	$686.95	$656.60	$611.99	$535.86	$531.87	$512.85	$503.55
48	$925.41	$716.41	$796.70	$790.64	$718.60	$686.85	$640.18	$560.54	$556.37	$536.48	$526.75
49	$965.60	$747.52	$831.30	$824.97	$749.80	$716.67	$667.98	$584.89	$580.53	$559.77	$549.62
50	$1,010.88	$782.57	$870.28	$863.66	$784.96	$750.28	$699.31	$612.31	$607.76	$586.02	$575.40
51	$1,055.59	$817.19	$908.78	$901.86	$819.69	$783.47	$730.24	$639.40	$634.64	$611.94	$600.85
52	$1,104.83	$855.31	$951.17	$943.93	$857.92	$820.02	$764.31	$669.22	$664.25	$640.49	$628.88
53	$1,154.64	$893.87	$994.05	$986.48	$896.60	$856.98	$798.76	$699.39	$694.19	$669.36	$657.23
54	$1,208.41	$935.49	$1,040.34	$1,032.42	$938.35	$896.89	$835.96	$731.96	$726.52	$700.54	$687.83
55	$1,262.18	$977.12	$1,086.63	$1,078.36	$980.11	$936.80	$873.16	$764.53	$758.85	$731.71	$718.44
56	$1,320.48	$1,022.25	$1,136.82	$1,128.17	$1,025.38	$980.07	$913.49	$799.85	$793.90	$765.50	$751.62
57	$1,379.34	$1,067.82	$1,187.50	$1,178.46	$1,071.09	$1,023.76	$954.21	$835.50	$829.29	$799.63	$785.13
58	$1,442.17	$1,116.46	$1,241.59	$1,232.14	$1,119.87	$1,070.39	$997.67	$873.56	$867.06	$836.05	$820.89
59	$1,473.30	$1,140.56	$1,268.39	$1,258.73	$1,144.04	$1,093.49	$1,019.20	$892.41	$885.77	$854.10	$838.61
60	$1,536.12	$1,189.19	$1,322.48	$1,312.41	$1,192.83	$1,140.12	$1,062.67	$930.47	$923.55	$890.52	$874.37
61	$1,590.46	$1,231.26	$1,369.26	$1,358.83	$1,235.02	$1,180.45	$1,100.26	$963.38	$956.21	$922.02	$905.30
62	$1,626.12	$1,258.86	$1,399.96	$1,389.30	$1,262.71	$1,206.92	$1,124.92	$984.98	$977.65	$942.69	$925.59
63	$1,670.83	$1,293.48	$1,438.45	$1,427.50	$1,297.43	$1,240.11	$1,155.86	$1,012.06	$1,004.54	$968.61	$951.05
64	$1,698.00	$1,314.51	$1,461.84	$1,450.71	$1,318.53	$1,260.27	$1,174.65	$1,028.52	$1,020.87	$984.36	$966.51
65 and over	$1,698.00	$1,314.51	$1,461.84	$1,450.71	$1,318.53	$1,260.27	$1,174.65	$1,028.52	$1,020.87	$984.36	$966.51

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 9

Rates Effective 6/1/14 through 5/31/15

Region 9 includes the counties of: Santa Cruz, Monterey, and San Benito

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$321.30	$248.73	$274.70	$272.61	$247.76	$236.82	$220.73	$193.27	$191.83	$184.98	$181.62
21	$505.98	$391.70	$432.60	$429.30	$390.18	$372.95	$347.61	$304.36	$302.10	$291.30	$286.02
22	$505.98	$391.70	$432.60	$429.30	$390.18	$372.95	$347.61	$304.36	$302.10	$291.30	$286.02
23	$505.98	$391.70	$432.60	$429.30	$390.18	$372.95	$347.61	$304.36	$302.10	$291.30	$286.02
24	$505.98	$391.70	$432.60	$429.30	$390.18	$372.95	$347.61	$304.36	$302.10	$291.30	$286.02
25	$508.00	$393.27	$434.33	$431.02	$391.74	$374.44	$349.00	$305.58	$303.31	$292.47	$287.16
26	$518.12	$401.10	$442.98	$439.60	$399.54	$381.90	$355.95	$311.66	$309.35	$298.29	$292.88
27	$530.27	$410.50	$453.36	$449.91	$408.91	$390.85	$364.30	$318.97	$316.60	$305.28	$299.75
28	$550.00	$425.78	$470.24	$466.65	$424.13	$405.40	$377.85	$330.84	$328.38	$316.64	$310.90
29	$566.19	$438.31	$484.08	$480.39	$436.61	$417.33	$388.98	$340.58	$338.05	$325.96	$320.06
30	$574.29	$444.58	$491.00	$487.26	$442.85	$423.30	$394.54	$345.45	$342.88	$330.63	$324.63
31	$586.43	$453.98	$501.38	$497.56	$452.22	$432.25	$402.88	$352.75	$350.13	$337.62	$331.50
32	$598.57	$463.38	$511.77	$507.86	$461.58	$441.20	$411.22	$360.06	$357.38	$344.61	$338.36
33	$606.16	$469.26	$518.25	$514.30	$467.44	$446.79	$416.44	$364.62	$361.92	$348.98	$342.65
34	$614.26	$475.52	$525.18	$521.17	$473.68	$452.76	$422.00	$369.49	$366.75	$353.64	$347.23
35	$618.31	$478.66	$528.64	$524.60	$476.80	$455.74	$424.78	$371.93	$369.17	$355.97	$349.52
36	$622.36	$481.79	$532.10	$528.04	$479.92	$458.73	$427.56	$374.36	$371.58	$358.30	$351.80
37	$626.40	$484.92	$535.56	$531.47	$483.04	$461.71	$430.34	$376.80	$374.00	$360.63	$354.09
38	$630.45	$488.06	$539.02	$534.91	$486.16	$464.70	$433.12	$379.23	$376.42	$362.96	$356.38
39	$638.55	$494.33	$545.94	$541.78	$492.41	$470.66	$438.68	$384.10	$381.25	$367.62	$360.96
40	$646.64	$500.59	$552.86	$548.65	$498.65	$476.63	$444.25	$388.97	$386.08	$372.28	$365.53
41	$658.79	$509.99	$563.25	$558.95	$508.01	$485.58	$452.59	$396.28	$393.33	$379.27	$372.40
42	$670.42	$519.00	$573.20	$568.82	$516.99	$494.16	$460.58	$403.28	$400.28	$385.97	$378.98
43	$686.61	$531.54	$587.04	$582.56	$529.47	$506.09	$471.71	$413.02	$409.95	$395.29	$388.13
44	$706.85	$547.20	$604.34	$599.73	$545.08	$521.01	$485.61	$425.19	$422.03	$406.95	$399.57
45	$730.64	$565.61	$624.67	$619.91	$563.42	$538.54	$501.95	$439.50	$436.23	$420.64	$413.01
46	$758.97	$587.55	$648.90	$643.95	$585.27	$559.43	$521.42	$456.54	$453.15	$436.95	$429.03
47	$790.85	$612.23	$676.15	$671.00	$609.85	$582.92	$543.31	$475.71	$472.18	$455.30	$447.05
48	$827.28	$640.43	$707.30	$701.91	$637.94	$609.77	$568.34	$497.63	$493.93	$476.28	$467.64
49	$863.20	$668.24	$738.02	$732.39	$665.65	$636.25	$593.02	$519.24	$515.38	$496.96	$487.95
50	$903.68	$699.58	$772.62	$766.73	$696.86	$666.09	$620.83	$543.59	$539.55	$520.26	$510.83
51	$943.65	$730.52	$806.80	$800.64	$727.69	$695.55	$648.29	$567.63	$563.42	$543.27	$533.43
52	$987.67	$764.60	$844.44	$837.99	$761.63	$728.00	$678.53	$594.11	$589.70	$568.62	$558.31
53	$1,032.20	$799.07	$882.50	$875.77	$795.97	$760.82	$709.12	$620.89	$616.28	$594.25	$583.48
54	$1,080.27	$836.28	$923.60	$916.56	$833.03	$796.25	$742.15	$649.81	$644.98	$621.93	$610.65
55	$1,128.34	$873.49	$964.70	$957.34	$870.10	$831.68	$775.17	$678.72	$673.68	$649.60	$637.82
56	$1,180.45	$913.84	$1,009.26	$1,001.56	$910.29	$870.09	$810.97	$710.07	$704.80	$679.60	$667.28
57	$1,233.07	$954.57	$1,054.25	$1,046.20	$950.87	$908.88	$847.13	$741.73	$736.22	$709.90	$697.03
58	$1,289.24	$998.05	$1,102.26	$1,093.86	$994.18	$950.28	$885.71	$775.51	$769.75	$742.23	$728.78
59	$1,317.07	$1,019.60	$1,126.06	$1,117.47	$1,015.64	$970.79	$904.83	$792.25	$786.37	$758.25	$744.51
60	$1,373.23	$1,063.07	$1,174.08	$1,165.12	$1,058.95	$1,012.19	$943.41	$826.03	$819.90	$790.59	$776.26
61	$1,421.80	$1,100.68	$1,215.61	$1,206.33	$1,096.41	$1,047.99	$976.78	$855.25	$848.90	$818.55	$803.72
62	$1,453.68	$1,125.35	$1,242.86	$1,233.38	$1,120.99	$1,071.49	$998.68	$874.43	$867.93	$836.90	$821.74
63	$1,493.65	$1,156.30	$1,277.04	$1,267.29	$1,151.81	$1,100.95	$1,026.14	$898.47	$891.80	$859.92	$844.33
64	$1,517.94	$1,175.10	$1,297.80	$1,287.90	$1,170.54	$1,118.85	$1,042.83	$913.08	$906.30	$873.90	$858.06
65 and over	$1,517.94	$1,175.10	$1,297.80	$1,287.90	$1,170.54	$1,118.85	$1,042.83	$913.08	$906.30	$873.90	$858.06

Monthly rates shown below are for Anthem medical premiums only. By law, all ACA plans must include coverage for pediatric dental benefits.
Rates for pediatric dental must be added to medical rates to calculate your monthly premium.
A separate $20 monthly administration fee will be added to total premium to calculate your total monthly rate.

Region 10

Rates Effective 6/1/14 through 5/31/15

Region 10 includes the counties of: San Joaquin, Stanislaus, Merced, Mariposa, and Tulare

	HMO Plans		PPO Plans								
Age on 6/1/14	Preferred Gold HMO (gzba)	Essential Silver 1500 Plus (gboa)	Preferred Gold 500 (gwfa)	Preferred Gold 1500 (gyfa)	Preferred Gold 1000 (gzfa)	Essential Silver 1500 (gtob)	Essential Silver 2000 Plus (gbqa)	Core Bronze HSA 3500 (gjua)	Core Bronze HSA 5500 (gmua)	Core Bronze HSA 4500 (gpua)	Core Bronze 5500 Plus (gsdf)
0-20	$344.99	$267.07	$215.30	$213.66	$194.19	$185.61	$173.01	$151.48	$150.36	$144.98	$142.35
21	$543.29	$420.59	$339.06	$336.47	$305.81	$292.30	$272.45	$238.55	$236.78	$228.31	$224.17
22	$543.29	$420.59	$339.06	$336.47	$305.81	$292.30	$272.45	$238.55	$236.78	$228.31	$224.17
23	$543.29	$420.59	$339.06	$336.47	$305.81	$292.30	$272.45	$238.55	$236.78	$228.31	$224.17
24	$543.29	$420.59	$339.06	$336.47	$305.81	$292.30	$272.45	$238.55	$236.78	$228.31	$224.17
25	$545.46	$422.27	$340.42	$337.82	$307.03	$293.47	$273.54	$239.50	$237.73	$229.22	$225.07
26	$556.33	$430.68	$347.20	$344.55	$313.15	$299.32	$278.99	$244.28	$242.46	$233.79	$229.55
27	$569.37	$440.78	$355.33	$352.62	$320.49	$306.33	$285.53	$250.00	$248.15	$239.27	$234.93
28	$590.56	$457.18	$368.56	$365.74	$332.42	$317.73	$296.15	$259.30	$257.38	$248.17	$243.67
29	$607.94	$470.64	$379.41	$376.51	$342.20	$327.08	$304.87	$266.94	$264.96	$255.48	$250.85
30	$616.63	$477.37	$384.83	$381.89	$347.09	$331.76	$309.23	$270.75	$268.75	$259.13	$254.43
31	$629.67	$487.46	$392.97	$389.97	$354.43	$338.78	$315.77	$276.48	$274.43	$264.61	$259.81
32	$642.71	$497.56	$401.11	$398.04	$361.77	$345.79	$322.31	$282.20	$280.11	$270.09	$265.19
33	$650.86	$503.87	$406.19	$403.09	$366.36	$350.18	$326.40	$285.78	$283.66	$273.52	$268.56
34	$659.55	$510.60	$411.62	$408.47	$371.25	$354.85	$330.75	$289.60	$287.45	$277.17	$272.14
35	$663.90	$513.96	$414.33	$411.17	$373.70	$357.19	$332.93	$291.51	$289.35	$278.99	$273.94
36	$668.25	$517.33	$417.04	$413.86	$376.15	$359.53	$335.11	$293.42	$291.24	$280.82	$275.73
37	$672.59	$520.69	$419.76	$416.55	$378.59	$361.87	$337.29	$295.32	$293.13	$282.65	$277.52
38	$676.94	$524.06	$422.47	$419.24	$381.04	$364.21	$339.47	$297.23	$295.03	$284.47	$279.32
39	$685.63	$530.78	$427.89	$424.63	$385.93	$368.88	$343.83	$301.05	$298.82	$288.13	$282.90
40	$694.32	$537.51	$433.32	$430.01	$390.83	$373.56	$348.19	$304.87	$302.60	$291.78	$286.49
41	$707.36	$547.61	$441.46	$438.08	$398.16	$380.57	$354.73	$310.59	$308.29	$297.26	$291.87
42	$719.86	$557.28	$449.25	$445.82	$405.20	$387.30	$361.00	$316.08	$313.73	$302.51	$297.03
43	$737.24	$570.74	$460.10	$456.59	$414.98	$396.65	$369.71	$323.71	$321.31	$309.82	$304.20
44	$758.98	$587.56	$473.67	$470.05	$427.22	$408.34	$380.61	$333.25	$330.78	$318.95	$313.17
45	$784.51	$607.33	$489.60	$485.86	$441.59	$422.08	$393.42	$344.47	$341.91	$329.68	$323.70
46	$814.94	$630.89	$508.59	$504.71	$458.72	$438.45	$408.68	$357.83	$355.17	$342.47	$336.26
47	$849.16	$657.38	$529.95	$525.90	$477.98	$456.86	$425.84	$372.85	$370.09	$356.85	$350.38
48	$888.28	$687.66	$554.36	$550.13	$500.00	$477.91	$445.46	$390.03	$387.14	$373.29	$366.52
49	$926.85	$717.53	$578.44	$574.02	$521.71	$498.66	$464.80	$406.97	$403.95	$389.50	$382.43
50	$970.32	$751.17	$605.56	$600.94	$546.18	$522.05	$486.60	$426.05	$422.89	$407.76	$400.37
51	$1,013.24	$784.40	$632.35	$627.52	$570.34	$545.14	$508.12	$444.90	$441.59	$425.80	$418.08
52	$1,060.50	$820.99	$661.85	$656.79	$596.94	$570.57	$531.82	$465.65	$462.19	$445.66	$437.58
53	$1,108.31	$858.00	$691.68	$686.40	$623.85	$596.29	$555.80	$486.64	$483.03	$465.75	$457.31
54	$1,159.92	$897.96	$723.89	$718.36	$652.90	$624.06	$581.68	$509.30	$505.53	$487.44	$478.60
55	$1,211.54	$937.92	$756.10	$750.33	$681.96	$651.83	$607.56	$531.97	$528.02	$509.13	$499.90
56	$1,267.50	$981.24	$791.03	$784.98	$713.45	$681.94	$635.63	$556.54	$552.41	$532.65	$522.99
57	$1,324.00	$1,024.98	$826.29	$819.98	$745.26	$712.34	$663.96	$581.35	$577.03	$556.39	$546.30
58	$1,384.30	$1,071.66	$863.92	$857.33	$779.20	$744.78	$694.20	$607.83	$603.32	$581.73	$571.19
59	$1,414.18	$1,094.80	$882.57	$875.83	$796.02	$760.86	$709.19	$620.95	$616.34	$594.29	$583.51
60	$1,474.49	$1,141.48	$920.21	$913.18	$829.97	$793.30	$739.43	$647.42	$642.62	$619.63	$608.40
61	$1,526.64	$1,181.86	$952.76	$945.48	$859.33	$821.36	$765.58	$670.33	$665.35	$641.55	$629.92
62	$1,560.87	$1,208.36	$974.12	$966.68	$878.59	$839.78	$782.75	$685.35	$680.27	$655.93	$644.04
63	$1,603.79	$1,241.58	$1,000.91	$993.26	$902.75	$862.87	$804.27	$704.20	$698.97	$673.97	$661.75
64	$1,629.87	$1,261.77	$1,017.18	$1,009.41	$917.43	$876.90	$817.35	$715.65	$710.34	$684.93	$672.51
65 and over	$1,629.87	$1,261.77	$1,017.18	$1,009.41	$917.43	$876.90	$817.35	$715.65	$710.34	$684.93	$672.51

C.A.R. HEALTH PLAN
How To Calculate Your Medical Rates

For Assistance, Call RealCare Insurance Marketing at (800) 939-8088

Step 1: Confirm Eligibility and Find Your Rating Region

Review the Rating Region guide to determine which rating region you should use. Your rate is determined by your county, and your home zip code. The zip code of a P.O. Box or other purchased mailbox may not be used. If you move to a different rating area during the year your rate will be updated on the first of the month following notice of your address change.

Step 2: Review Plan Options

Find the plan you want from the Anthem Plan Comparison and benefit summaries available on the RealCare website. Once you select a plan, you will only be allowed to change it during Open Enrollment or if you experience a qualifying event. Information on benefits and rates for all plans and coverage options are available online.

If you wish to confirm your eligibility you can call RealCare at (800) 939-8088, Ext. 202.

Once you've decided which plan you want and who you want to cover, use the worksheet below to calculate your premiums. All rates will be confirmed by RealCare.

Step 3: Medical Rate Worksheet

- Write in the name of the plan you've selected and locate the plan on the rate page for your rating region
- List each family member you want to cover on the worksheet below
- Enter the rate for each family member, based on their age as of 6/1/14
- For children under 21, include a rate for only the three oldest children
- For children 21 and older, enter each child's rate
- Add the rate for Pediatric Dental Benefits (see chart to right)
- Add the rates and monthly administration fee to determine your total

2014 Health Plan Selection: _____

	Family Member Name	Age as of 6/1/14	Medical Rate
C.A.R. Member			$
Spouse/DP			$
Child			$
Child			$
Child			$
Child			$
Monthly Pediatric Dental			**$**
Monthly Administration Fee			**$ 20.00**
Total			**$**

Monthly Pediatric Dental Rates

Rates effective 6/1/14 through 5/31/15

Add to medical to calculate total rate.

Region 1	
Member Only	$5.36
Member + Spouse	$10.72
Member + Child(ren)	$14.03
Member + Family	$21.55

Regions 2, 3, 9, 15, 18, 19	
Member Only	$5.87
Member + Spouse	$11.74
Member + Child(ren)	$15.36
Member + Family	$23.58

Regions 4, 8	
Member Only	$6.89
Member + Spouse	$13.78
Member + Child(ren)	$18.04
Member + Family	$27.69

Regions 5, 6, 7	
Member Only	$6.69
Member + Spouse	$13.37
Member + Child(ren)	$17.50
Member + Family	$26.87

Regions 10, 13, 17	
Member Only	$4.77
Member + Spouse	$9.54
Member + Child(ren)	$12.48
Member + Family	$19.17

Regions 11, 14	
Member Only	$4.53
Member + Spouse	$9.07
Member + Child(ren)	$11.86
Member + Family	$18.22

Regions 12, 16	
Member Only	$5.36
Member + Spouse	$10.72
Member + Child(ren)	$14.03
Member + Family	$21.55

Delta Dental Plan Options through the Associations

Effective Date: December 01, 2014 - November 30, 2015

Insurance Carrier	DeltaCare USA #06266-0001	Delta Dental #7314-0190
Plan Name	Plan 11B	Fee For Service
Plan Type	DHMO	Premier DPO
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
	Additional Cleanings: $45.00	Not Applicable
Child through Age 13	No Charge	$32.00
	Additional Cleanings: $35.00	Not Applicable
		"Delta Pays" (A)
Restorative	No Charge - $240 copay	$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
		"Delta Pays" (A)
Waiting Period	None	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	NOT COVERED
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	53.55
Subscriber+1	58.47	94.10
Subscriber+2 or more	82.42	123.40

(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 Date December 01, 2014 - November 30, 2015

MEDICAL EYE SERVICES (MES)		
Vision Benefits	**In-Network**	**Out-of-Network**
Deductible: **Exams** **Material**	 **$10 deductible** **$15 deductible**	 **$10 deductible** **$15 deductible**
Exam	**One comprehensive exam in any 24 consecutive months, with a follow-up exam at a 12 month interval.**	
Comprehensive Exam **Follow-Up Exam**	**No Charge** **No Charge**	**Up to $40** **Up to $20**
Lenses (per pair)	**1 pair of standard lenses in any 24 consecutive months, or at a 12 month interval if the prescription changes.**	
Frames	**1 standard frame in any 24 consecutive months.**	
	Up to retail cost of $100	**Up to $40**
Contact Lenses	**1 pair of standard lenses in any 24 consecutive months, or at a 12 month interval if the prescription changes.**	
Cosmetic/Convenience **Medically Necessary**	**Up to $105** **No Charge**	**Up to $100** **Up to $250**

Application Requirements

Member/Employer group applications may be submitted at any time. Applications for new hires should be enrolled within 30 days following the date of eligibility. Dependents must be enrolled during initial enrollment period. If a member enrolls at any other time than December, the annual rate will be pro-rated.

Premium Rates

	Subscriber	**Subscriber & Spouse OR Subscriber & (1) Child**	**Subscriber & Family**
Monthly Rates	**$7.95**	**$14.95**	**$20.10**
Annual Rates	**$95.40**	**$179.40**	**$241.20**

Other Services:

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