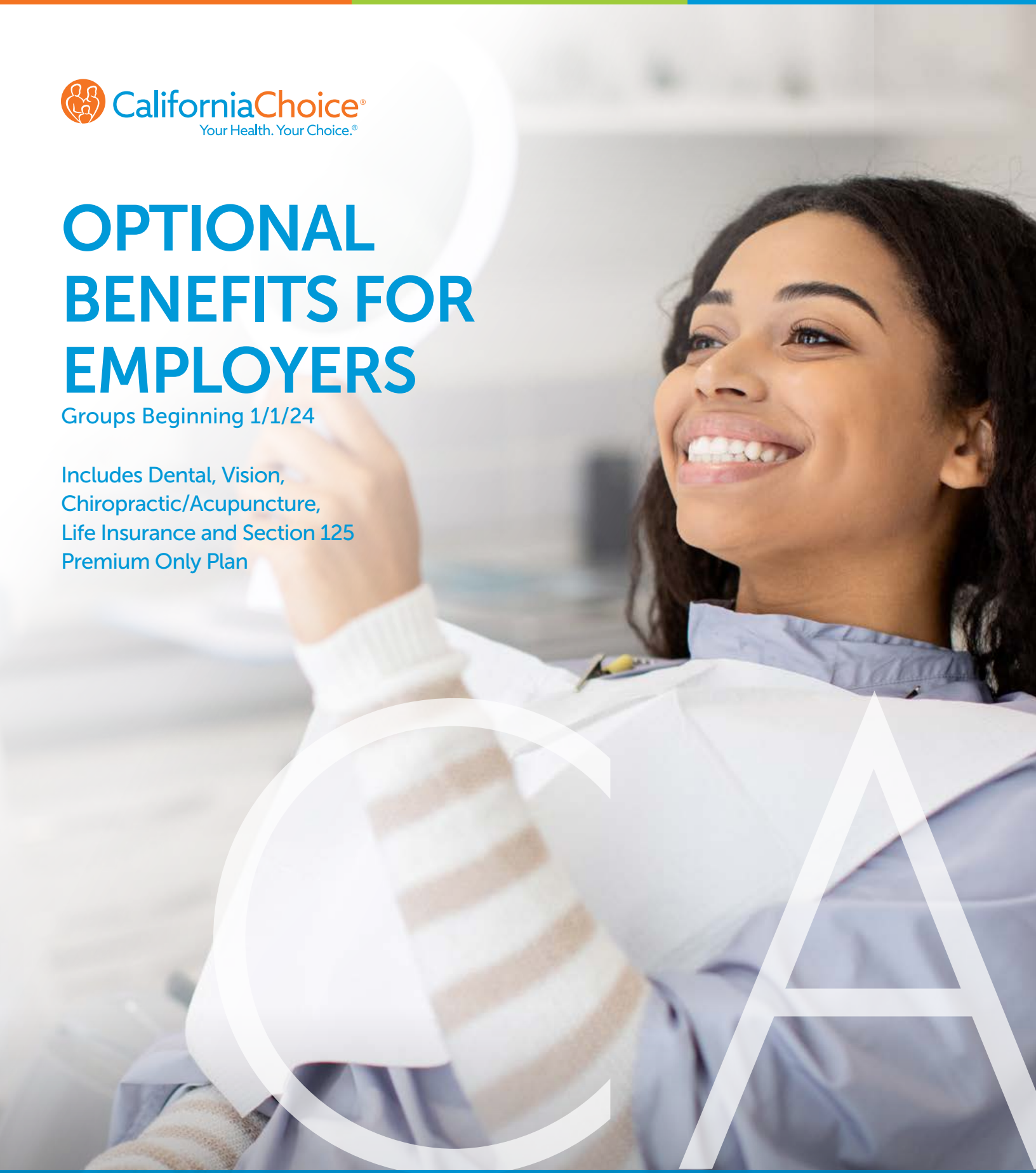
CaliforniaChoice®
Your Health. Your Choice.®

OPTIONAL BENEFITS FOR EMPLOYERS

Groups Beginning 1/1/24

Includes Dental, Vision, Chiropractic/Acupuncture, Life Insurance and Section 125 Premium Only Plan



Anthem
cigna + oscar
health net
KAISER PERMANENTE®
SHARP Health Plan
Sutter Health Plus Your Health Plan
UnitedHealthcare
westernhealth ADVANTAGE

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The benefits listed in this brochure were collected from all plans participating in the CaliforniaChoice® Program and are accurate to the best of our knowledge at the time of print. If the information in this brochure differs from the information in the EOC (Evidence of Coverage) or COI (Certificate of Insurance), the EOC or COI applies.

Each plan offered in the CaliforniaChoice Program meet the requirements of the Affordable Care Act (ACA).

Participation and Contribution Requirements

Groups Beginning 1/1/24

Dental

- 1-2 Employees: 100% of all employees. All groups must include at least one dental enrolled employee who is not a business owner or spouse of business owner.
- 3-100 Employees: 70% of eligible employees enrolling in CaliforniaChoice®.
- Minimum dependent participation is 0%.
- If you are offering Buy-Up Dental Plans to your employees, it is required that you pay at least 50% of the employee only premium of the lowest cost plan offered.
- If Voluntary Dental is selected, no employer contribution or minimum participation is required.

Vision One Eyecare Discount Program

- No employer contribution or minimum participation required.
- Medically enrolled members not enrolling for Voluntary Vision will automatically receive our discount vision plan.

Voluntary Vision Program

- The employer must offer the program for member to elect.
- No minimum participation required.
- The employee must pay 100% of premiums.

ChiroPlus Program

- This program requires the employer to contribute 100% with all CaliforniaChoice medically enrolled employees participating.

Life Insurance

- If purchasing the life option, 100% participation is required. Therefore, ALL employees eligible for medical coverage (even those waiving medical), must enroll in life.
- 100% of the premium will be the employer's responsibility.
- At initial enrollment you may select either:
  1. One flat amount offered equally to all employees ($10,000 minimum — in $5,000 increments).
  2. Different insurance amounts ($5,000 increments) for up to 4 employee classifications with the highest amount of insurance no greater than 2.5 times the lowest amount selected.
- If adding life after initial enrollment, you may select one flat amount offered equally to all employees ($5,000 minimum – in $5,000 increments).

MetLife DHMO MET100, MET185 and SmileSaver℠ DHMO 3000, 1000 Benefit Summaries

(Also available as Voluntary Plans)

This is a summary of benefits for the MetLife DHMO MET100, MET185 and SmileSaver DHMO 3000, 1000 plans offered through CaliforniaChoice®. To be eligible, your business must be located within the plan service area. Employees enrolling in one of these plans must choose a participating dentist from the MetLife Dental HMO/Managed Care Network. Employees can access the Online Provider Directory at https://www.calchoice.com/ProviderLandingPage.aspx.

Plan Benefits	MetLife Plan MET100	MetLife Plan MET185	SmileSaver Plan 3000	SmileSaver Plan 1000
Exam & Diagnostics				
Office Visits	$5 Copay	$5 Copay	No Charge	No Charge
Initial Oral Exam	No Charge	No Charge	No Charge	No Charge
Periodic Oral Exam	No Charge	No Charge	No Charge	No Charge
Teeth Cleaning	No Charge	No Charge	No Charge	No Charge
X-Rays Bite-Wing (4 films)	No Charge	No Charge	No Charge	No Charge
Oral Surgery				
Removal of Uncomplicated Single Tooth	No Charge	No Charge	$10 Copay	No Charge
Removal of Impacted Tooth – partially bony	$40 Copay	$65 Copay	$50 Copay	No Charge
Removal of Impacted Tooth – completely bony	$75 Copay	$80 Copay	$65 Copay	No Charge
Restorative				
Cavities – Amalgam 1 Surface	No Charge	$10 Copay	$9 Copay	No Charge
Cavities – Amalgam 2 Surfaces	No Charge	$15 Copay	$14 Copay	No Charge
Endodontics				
Single Root Canal	$40 Copay	$80 Copay	$100 Copay	$40 Copay
Bi-Root Canal	$65 Copay	$115 Copay	$135 Copay	$65 Copay
Molar Root Canal	$95 Copay	$200 Copay	$185 Copay	$95 Copay
Periodontics				
Gingivectomy – Per Tooth	$38 Copay	$68 Copay	$30 Copay	No Charge
Periodontal Scaling & Root Planing (quadrant)	$25 Copay	$40 Copay	$26 Copay	$20 Copay
Crowns – Single Restoration				
Porcelain – Base Metal (posterior)	$175 Copay†	$260 Copay†	$225 Copay†	$175 Copay†
Full Cast Noble Metal	$100 Copay†	$185 Copay†	$115 Copay†	$60 Copay†
Orthodontics**				
Child (maximum age 18)	$1,450 Copay	$1,695 Copay	$1,600 Copay	$1,600 Copay
Adult	$1,450 Copay	$1,695 Copay	$1,950 Copay	$1,950 Copay
Prosthodontics				
Complete Upper or Lower Denture	$125 Copay	$210 Copay	$120 Copay	$70 Copay
Partial Upper or Lower Denture	$110 Copay	$240 Copay	$110 Copay	$50 Copay

Note: Copays listed for Plans MET100, MET185, 3000 and 1000 are for services performed by general dentists. Please consult the EOC/SOB for specialist copays and any additional fees that may apply to specific procedures.

† Cost of high noble metal (gold, etc.) may be charged extra when used. Not to exceed actual laboratory cost of metal.

** 24 month treatment.

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

MetLife DHMO MET100 & MET185

Exclusions & Limitations

General

- Specialty Care Dentists will accept the contracted fee for all Covered Services.
- Sterilization and infection control are not billable to Us or You or Your Dependent and are included within the charges for other services provided on that date of service.

Diagnostic

- Panoramic or full mouth x-rays (including bitewings): once every three (3) years, unless Dentally Necessary for a specific dental problem.
- All costs for additional periapical and bitewing x-rays provided on the same day that a full mouth x-ray is provided to You or Your Dependent are included in the costs for the full mouth x-ray.

Preventive

- Routine cleanings (oral Prophylaxis), periodontal maintenance services (following active periodontal therapy) and fluoride treatments are limited to twice a year. Two (2) additional cleanings (routine and periodontal) are available at the Co-Payment listed in the SCHEDULE OF BENEFITS. Additional Prophylaxis are available, if Dentally Necessary.

Restorative Treatment
Crowns, Implants and Fixed Bridges

- An additional charge, not to exceed $150 per unit, will be applied for any procedure using noble, high noble or titanium metal.
- There is a $75 Co-Payment per molar, for the use of porcelain.
- Charges for temporary Crowns/restorations are included within the costs of the permanent Crown/restoration.

Prosthodontics

- Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such Dentures under a SafeGuard Plan, unless due to the loss of a natural tooth which cannot be added to the existing partial. Replacements will be a benefit under this Plan only if the existing Denture is unsatisfactory and cannot be made satisfactory as determined by the treating Selected General Dentist or Specialty Care Dentist.

Endodontics

- The Co-Payments listed for Endodontic procedures do not include the cost of the final restoration.

Periodontics

- Periodontal scaling and root planing, is limited to not more than once per Quadrant in any twenty-four (24) month period.
- Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, is limited to no more than one surgical procedure per Quadrant in any thirty-six (36) month period.

Orthodontics

- If You or Your Dependent require the services of an orthodontist, a referral must first be facilitated by Your Selected General Dentist. If a referral is not obtained before the Orthodontic treatment begins, You will be responsible for all costs associated with any Orthodontic treatment.
- Plan benefits shall cover twenty-four (24) months of usual and customary Orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a charge of $25 per visit.

MetLife DHMO MET100 & MET185

Exclusions & Limitations (Continued)

EXCLUSIONS:

- Any procedures not specifically listed as a Covered Service in this SCHEDULE OF BENEFITS or dental procedures or services performed solely for Cosmetic purposes (unless specifically listed as a Covered Service in this SCHEDULE OF BENEFITS), are not covered.
- Covered Services must be performed by Your Selected General Dental Office or a SafeGuard Specialty Care Dentist to whom You are referred in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS. Services performed by any Dentist not contracted with SafeGuard are not Covered Services, without prior approval by SafeGuard or Your Selected General Dentist, in accordance with the terms of Your evidence of coverage and SCHEDULE OF BENEFITS (except for out-of-area emergency services).
- Dental procedures started prior to Your or Your Dependent's eligibility under this SCHEDULE OF BENEFITS or started after Your or Your Dependent's benefits have ended. For example, teeth prepared for Crowns, root canals in progress (the tooth has been opened into the pulp (nerve chamber)), or full or partial Dentures for which an impression has been taken.
- Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by the Selected General Dentist, and Us based on generally accepted dental standards of care.
- Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
- Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in the SCHEDULE OF BENEFITS. Any services related to pathology laboratory fees.
- Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital malformation, developmental, or medically induced dental disorders including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specifically listed as a Covered Service in this SCHEDULE OF BENEFITS.
- Dental services considered Experimental in nature.
- Treatment required due to an accident from an external force, unless otherwise listed as Covered Service in this SCHEDULE OF BENEFITS.
- The following are not included as Orthodontic benefits:
  - Repair or replacement of lost or broken appliances;
  - Retreatment of Orthodontic cases;
  - Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances.
  - Invisalign services are excluded

This is a summary of Limitations, Additional Charges & Exclusions Only. For a complete listing, refer to the appropriate Schedule of Benefits and Evidence of Coverage.

SmileSaver℠ DHMO Plan 3000 and 1000

Exclusions & Limitations

- Dental treatment must be received from the Member's participating dental office unless exception is specifically authorized in writing by the Plan.
- Routine and periodic examinations are limited to once every 6 months per enrolled Member.
- Prophylaxis procedures are limited to once every 6 months.
- Bitewing radiographs (x-rays) in conjunction with periodic examinations are limited to one series films in any 12 consecutive month period. Full mouth radiographs (x-rays) in conjunction with periodic examinations are limited to once every 3 years. Panoramic films are limited to once every 3 years.
- Fluoride treatment is limited to enrolled Members under the age of 18 years once every 6 months.
- Periodontal scaling and root planing, and/or sub-gingival curettage, and periodontal maintenance procedures are limited to one course of therapy during any 12 month period.

The following dental services and procedures are not included in the Dental DHMO 3000 or 1000:

- Any procedure not specifically listed as a covered benefit.
- Dental treatment or expenses incurred in connection with any dental procedures started prior to the Member's effective date under this Plan or after termination of the Member's coverage. Example: teeth prepared for crowns, root canal treatment in progress, etc.
- All treatment of fractures and dislocations.
- Extraction for orthodontic purposes.
- Dental procedures and charges incurred as part of implants (placement or removal) and prosthetic devices placed on implants (fixed or removable). Example: bridges, crowns, dentures.
- Replacement of lost or stolen dentures, crown and bridgework or other dental appliances.
- Dental treatment or procedures requiring or associated with fixed prosthodontic restorations (other than those for replacement of structure lost due to decay) when part of extensive oral rehabilitation or reconstruction.
- Diagnosis or treatment by any method of any condition related to the jaw joint, TMJ or associated musculature, nerves or other tissues.
- A dental treatment plan, which, in the opinion of the Participating Dentist, is not medically necessary, will not produce a beneficial result or has a poor prognosis.
- Any corrective treatment required as a result of dental services performed by a non-participating dentist while this coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dental office or the Plan for completion or compensation.

This is a summary of Exclusions & Limitations only. For a complete listing, please see the Evidence of Coverage.

Ameritas PPO Plans 3000, 3500, 4000 & 5000 Benefit Summaries

(Also available as Voluntary Plans)

This is a summary of benefits for the PPO 3000, 3500, 4000 & 5000 underwritten by Ameritas, a division of Ameritas Life Insurance Corp.

	PPO 3000[2,3]		PPO 3500[2,3]		PPO 4000[2,3]		PPO 5000[2,3]	
Plan Benefits	In-Network	Out-of-Network†	In-Network	Out-of-Network†	In-Network	Out-of-Network†	In-Network	Out-of-Network†
Annual Maximum	$1,100	$700	$1,100[1]	$1,100[1]	$1,300[1]	$1,100[1]	$1,700[1]	$1,400[1]
Annual Deductible	$50 (Max 3x/Fam)	$100 (Max 3x/Fam)	$50 (Max 3x/Fam)	$50 (Max 3x/Fam)	$25 (Max 3x/Fam)	$75 (Max 3x/Fam)	$25 (Max 3x/Fam)	$75 (Max 3x/Fam)
Preventive Care	Ded. waived	Ded. waived	Ded. waived	Ded. applies	Ded. waived	Ded. applies	Ded. waived	Ded. applies
Preventive	100%	80%	100%	100%	100%	80%	100%	80%
Basic	80%	80%	80%/90%/100%*	80%	80%/90%/100%*	80%	80%/90%/100%*	80%
Major** (12 mo. wait period)	50%	50%	80%	50%	50%	50%	50%	50%
Endo/Perio**	50%	50%	80%	50%	80%	50%	80%	50%
"Fusion" Vision Reimbursement								
Annual Maximum	N/A		$100***		$100***		$100***	

† Plan 3000 and 3500 out-of-network claims are reimbursed at MAB. Plan 4000 and 5000 out-of-network claims are reimbursed at UCR.

* Submit one covered dental claim each year and your Basic procedures will advance to the 90% level the following plan year and to 100% on the third year.

** 12 month waiting period applies. Waiting period will be waived for Groups with 10+ employees and 12 months continuous uninterrupted dental coverage on previous plan.

*** Annual maximum per calendar year to spend at any eye care provider. File claim with Ameritas for reimbursement.

1 Annual maximum is a dental/vision combined benefit; you choose how to spend your maximum - it may be used toward dental and/or eye care expenses with a maximum of $100 toward eye care expenses.

2 Please consult the applicable plan certificate for specific plan details.

3 Includes Maternity Benefit which provides an additional comprehensive evaluation and cleaning during pregnancy (See EOC for details).

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Please Note:

- Employer must contribute at least 50% of the employee premium of the lowest cost dental plan being offered.
- Employees with other group coverage are not counted towards participation unless employer contribution is 100%.
- All groups without comparable dental coverage are subject to the waiting periods for major and ortho.

Dental Rewards® by Ameritas

Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed below, they can increase their next year's coverage by $250 and earn an additional $100 to $150 if they visit a network provider. For more information on Dental Rewards, please visit www.ameritas.com. (Dental Rewards is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)

	PPO 3000	PPO 3500	PPO 4000	PPO 5000
Carry Over Amount	N/A	$250	$250	$250
PPO Bonus	N/A	$100	$100	$150
Benefit Threshold	N/A	$500	$500	$750
Maximum Carry Over Amount	N/A	$1,000	$1,000	$1,000

Ameritas PPO Plans 3000, 3500, 4000 & 5000 Benefit Summaries

(Continued)

(Also available as Voluntary Plans)

Orthodontia is an optional benefit selected for the entire group by the employer.

Optional Orthodontia	PPO 3000		PPO 3500*	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Orthodontia (12 mo. wait period)**	Not Covered	Not Covered	50%	50%
Annual Maximum	Not Covered	Not Covered	None	None
Lifetime Maximum	Not Covered	Not Covered	$ 1,000	$ 1,000
Optional Orthodontia	**PPO 4000***		**PPO 5000***	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Orthodontia (12 mo. wait period)**	50%	50%	50%	50%
Annual Maximum	None	None	None	None
Lifetime Maximum	$ 1,000	$ 1,000	$ 1,000	$ 1,000

Note: Treatment must begin prior to 19th birthday.

* Available to groups of 5 or more eligible employees.

** 12 month waiting period applies. Waiting period will be waived for groups with 10+ employees and 12 months continuous uninterrupted orthodontia coverage on previous plan.

Ameritas Extras*

Members enrolled on the PPO 4000 or PPO 5000 now have LASIK and Hearing Care Coverage benefits! These benefits are not tied to a network so members can seek services from any LASIK or hearing care provider. The benefits can even be used in conjunction with discounts or specials offered by the provider.

The LASIK benefit makes it more affordable for members to obtain laser vision corrections and reduce their dependency on glasses or contacts.

The hearing benefit provides coverage for an annual hearing exam and helps cover the cost of hearing devices and maintenance.

LASIK Lifetime Benefit per Eye[1]	Benefit
Lifetime maximum per person[2]	$175 if used in year 1
	$175 if used in year 2
	$350 if you wait and use it in year 3

Annual Hearing Exam Benefit[1]	$75
Hearing Aid Benefit per Ear[3,4]	$100 is used in year 1
	$300 if used in year 2
	$400 if used in year 3
Hearing Aid Maintenance Batteries, service contracts, fittings, ear mold and repairs	$40

* Lasik and Soundcare benefits are available to groups with 5+ enrolled Dental PPO members.

1 This is only a summary of benefits. Please consult Ameritas Certificate for complete coverage details.

2 The maximum is per eye and cannot be combined toward double coverage for a single eye.

3 Once the hearing benefit is used, at any level, members become re-eligible for the benefit, at the top level, after five (5) years as long as there is not break in coverage. A reduced benefit is available after three (3) years if there is hearing deterioration the current aids can't correct, as long as there is no break in coverage.

4 Plan pays 50% of hearing aid cost up to the maximum benefit amount. The maximum is per ear and cannot be combined toward double coverage for single ear.

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Ameritas PPO Plans 3000, 3500, 4000 & 5000

Exclusions & Limitations

No benefits will be paid for expenses incurred:

- For overdentures and associated procedures.
- For charges in excess of those considered reasonable and customary.
- For cosmetic procedures.
- For the replacement of dentures, bridge inlays, onlays or crowns that can be repaired or restored to normal function.
- For implants and:
- Replacement of lost or stolen appliances
- Replacement of retainers
- Athletic mouthguards
- Precision or semi-precision attachments
- Dental duplication or sealants
- For oral hygiene instructions and:
- Plaque control
- Completion of a claim form
- Acid etch
- Missed appointments
- Prescription of take home fluoride
- Diagnostic photographs
- For services not completed when insurance ends, except that certain services which began while insured may be covered if completed within 31 days of termination of coverage.
- For procedures that have begun but have not been completed.
- For services and treatment provided at no charge, with or without insurance coverage.
- For services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
- For a condition covered under any Workers' Compensation Act or similar law.
- That are applied toward satisfying a deductible.
- That are generally considered by the dental profession as experimental or investigational.
- For the treatment of cleft palate and anodontia.
- For services or supplies payable under any medical expense plan.
- For orthodontia, unless included within Coverage Schedule.
- Prior to the date the insured is covered under the policy.
- For the diagnosis or treatment of TMJ.
- For hospital services.
- For any child 26 years of age and over.
- During any waiting period we require, when you voluntarily end your insurance and re-enroll at a later date. Your waiting period is 2 years and begins on the date your coverage first ended.
- Charges for infection control, sterilization and waste disposal.

This is a summary of Exclusions & Limitations Only. For a complete listing, please see the Evidence of Coverage.

Vision One Eyecare Discount Program Benefit Summary

by EyeMed provided by Ameritas

The Vision One Eyecare Discount Program from EyeMed provided by Ameritas offers discounts on frames, lenses, and eye examinations at any Sears, JCPenney, Target optical centers, LensCrafters, and participating Pearle Vision locations.

Vision One Features

- No claims to file
- No waiting for reimbursement
- Unlimited access

	Vision One Eyecare Discount Program
Eye Examinations*	**Employee Savings**
Routine Exam	$5 Savings
Contact Lens Exam	$10 Savings
Frames	Up to 40% off any frame available at provider locations
Lenses	**Employee Cost**
Single Vision	$50
Bifocal	$70
Trifocal	$105

Lens Options	**Employee Cost**
Standard-progressive (no line bifocals; amount added to bifocal cost)	$65
Polycarbonate	$40
Scratch resistant coating	$15
Ultraviolet coating	$15
Solid or gradient tint	$15
Anti-reflective coating	$45
Photochromic	20% Discount
Contact Lenses (2 ways to save) 1. Visit one of thousands of nationwide locations and save 15% off non-disposable contacts. 2. Use the Contact Lens replacement program for additional savings and convenience. Details are available at www.eyemedcontacts.com or call 800-508-1399.	

Participating providers are independent contractors solely responsible for vision examinations and products.

Pearle Vision, Inc. does not employ Doctors of Optometry and does not provide eye exams in California. Pearle VisionCare, Inc., a licensed vision healthcare service plan, provides eye exams in California.

Discounts cannot be used with other discounts, promotions, or prior orders.

* Provided by licensed independent Doctors of Optometry.

Voluntary Vision Plan Benefit Summary

by EyeMed provided by Ameritas

This is a summary of benefits for the Voluntary Vision Plan by EyeMed provided by Ameritas.

	Voluntary Vision by EyeMed	
	In-Network Cost	Out-of-Network Reimbursements
Eye Examinations		
Routine Eye Exam (1 per 12 months)	$10	up to $20
Frames (choice of any available frame) (1 per 12 months)		
Up to $100 **Plus 20% off balance over $100	Covered in Full**	up to $30
Lenses (standard uncoated plastic) (1 per 12 months)		
Single vision	$10	up to $20
Bifocal	$10	up to $30
Trifocal	$10	up to $40
Standard-progressive (no line bifocals; amount added to bifocal cost)	Covered in Full	Not Covered
Lens Options (add to lens prices above)		
Anti-reflective coating	$45	Not Covered
Polycarbonate	$40	Not Covered
Scratch resistant coating	$15	Not Covered
Ultraviolet coating	$15	Not Covered
Solid or gradient tint	$15	Not Covered
Photochromic	20% Discount	Not Covered
Contacts (one purchase per 12 months – in lieu of lenses and frames up to $100 retail value)		
Daily & extended wear	$10	$50
Disposable	$10	$50
Contact Lens Fitting		
Standard	Covered in Full	$40
Premium	90% of charges (less $40 allowance)[1]	$40

Participating retailers include: LensCrafters, America's Best, EyeMart Express, participating Pearle Vision Centers, Target Optical and many Independent Providers.

1 Coinsurance is member responsibility.
Co-payments listed are Member responsibility.

Voluntary Vision Plan Benefit Summary

by VSP provided by Ameritas

This is a summary of benefits for the Voluntary Vision Plan by VSP provided by Ameritas.

	Voluntary Vision by VSP	
	In-Network Cost	Out-of-Network Reimbursements
Eye Examinations		
Routine Eye Exam (1 per 12 months)	$10	up to $45
Frames (choice of any available frame) (1 per 12 months)		
Up to $180	Covered in Full	up to $70
Lenses (1 per 12 months)		
Single vision	$10	up to $30
Bifocal	$10	up to $50
Trifocal	$10	up to $65
Standard-progressive (no line bifocals; amount added to bifocal cost)	$55	up to $50
Lens Options (add to lens prices above)		
Anti-reflective coating	$43-$85	Not Covered
Polycarbonate	Covered in Full for dependent children, $33 adults	Not Covered
Scratch resistant coating	$17-$33	Not Covered
Ultraviolet coating	$16	Not Covered
Solid or gradient tint	$15-$17	Not Covered
Photochromic	$31-$82	Not Covered
Contacts (one purchase per 12 months – in lieu of lenses and frames up to $180 retail value)	$10	up to $105
Contact Lens Fitting		
Elective	Covered in Full after member cost of up to $60	15% Discount

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Chiropractic/Acupuncture Benefit Summary

by Landmark™ Healthplan

Landmark Healthplan Chiropractic and Acupuncture benefits are available for a low monthly fee with copays as low as $15 per visit for up to 20 visits per plan year.

	Plan 1	Plan 2
	Chiro Only	Chiro and Acupuncture
Office Visits Includes examinations, manipulation, conjunctive physiotherapy and X-Rays	$15 Copay Per Visit Maximum - 20 Visits Per Plan Year	$15 Copay Per Visit Maximum - 20 Visits Per Plan Year (combined between Chiropractic and Acupuncture)
Acupuncture Treatment **Herbal Therapies***	Not Covered Not Covered	$15 Copay Per Visit $5 Copay Per Bottle (Maximum $500 per plan year)
Chiropractic Discounts Office Visits Examinations Adjustments Diagnostic Procedures & X-Rays Chiropractic Medical Appliances	In addition to the 20 office visits for $15 each, members will receive additional discounts through Landmark Healthplan's network of providers. These additional discounts are listed below, but are not limited to:	
	Minimum 25% Discount for Professional Services	Minimum 25% Discount for Professional Services
Acupuncture Discounts Office Visits Examinations Diagnostic Procedures All Acupuncture Procedures (Includes electro-acupuncture, moxibustion, acupressure and cupping)	Not Covered	Minimum 20% Discount for Professional Services

* Herbal Therapies are for oral ingestion or external application of naturally occurring botanical, animal, or mineral substances to support normal structure and function of the human body according to the principles of traditional Oriental medicine.

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

Life Insurance/AD&D Benefit Summary

by Assurity Life Insurance Company

This benefit allows you to help your employees provide for loved ones in the event of death. Plan advantages include:

- A $10,000 minimum life insurance amount and higher guaranteed issue amounts (based on employee participation).

Initial Enrollment

Employee Participation	Guaranteed Issue* Maximum
1-10	$25,000
11-25	$50,000
26-50	$ 75,000
51-100	$100,000

After Initial Enrollment

Eligible Employee	Guaranteed Issue Life Amounts
	Up To:
1-5	$5,000
6-10	$10,000
11-25	$25,000
26-100	$50,000

- Partial payment of the life insurance amount to terminally ill through the Living Benefits Provision.
- Accidental Death & Dismemberment Benefit — this provision pays an additional amount equal to the life insurance amount (Loss must occur within 90 days of accident).
- Disability Waiver of Premium: Disability prior to age 60 - benefits to age 65.
- Conversion Privilege - within 31 days of termination, no medical exam.

Life insurance amounts are subject to the following reductions:

Reduction Schedule	
Age of Insured	% of coverage prior to age 70
70-74	70%
75+	40%

* Life insurance coverage is only guaranteed issue when elected at time of initial enrollment by group with CaliforniaChoice®.
Note: A suicide exclusion applies to life insurance amount during the first 2 years and to AD&D at any time.

Section 125 Premium Only Plan (POP)* Benefit Summary

by WageWorks, a HealthEquity company

This innovative benefit helps employees pay for their share of health premiums with pre-tax income. This results in less taxes paid by employees, and lower payroll taxes and Workers' Compensation costs for the employer.

Other POP Plan advantages:

- Pre-tax deduction allows employees to take home more money
- Employee tax savings make it easier for them to assume a larger share of the premium or "buy-up" to the benefit design of their choice

Here is a sample breakdown of savings offered by a Premium Only Plan (POP):

Employer Savings

Based on 30 employees, average $2,000/mo. salary

	Before POP Plan	With POP Plan
Employee Salary	$2,000	$2,000
Employee Premium Contribution	$0	$150
Taxable Salary	$2,000	$1,850
FICA at 7.65%	$153	$141
Workers' Comp (Average 3%)	$60	$55
Total Employee Payroll Cost	$2,213	$2,196
Monthly per employee savings:		$17
Annual employee savings:		$204
1st year savings with 30 employees:		$6,120

Employee Savings

Savings per employee, based on $2,000/mo. salary

	Before POP Plan	With POP Plan
Employee Salary	$2,000	$2,000
Tax Free Benefit Expenses (Redirected from salary on pre-tax basis)	$0	$150
Taxable Salary	$2,000	$1,850
Taxes & FICA (Average 25%)	$500	$462
Take Home Pay	$1,500	$1,388
After-Tax Premium Contribution	$150	$0
Spendable income:	$1,350	$1,388
Employee monthly increase:		$38
Annual increase and $0 raise:		$456

* Initial set-up fee is covered at no cost.

About WageWorks, a HealthEquity company

For more than 20 years, WageWorks has delivered a wide range of employee benefit administration solutions to employers, third party administrators (TPAs), business outsourcing partners and health plans across the nation. Specializing in the complex areas of administration and compliance, its expertise includes COBRA and HIPAA Administrative Services; Direct Bill Services for Retirees, Leave of Absence (LOA) and Family Medical Leave Act (FMLA); and Flexible Benefits Administration, including Section 125 Flexible Spending Accounts (FSA), Section 132 Transportation Plans, Section 105 Health Reimbursement Arrangements (HRA), and Health Savings Accounts (HSA). WageWorks was the nation's first outsourcing provider to offer benefits administration on a single Web-based, fully integrated system and is the only benefits administrator to offer performance standards and guarantees to all clients, regardless of size. For more information, visit the company's website at **www.wageworks.com**.

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