

Company Name

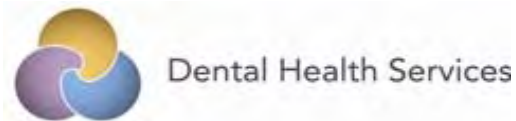


DENTAL • VISION • ORTHODONTIA BENEFITS

TripleChoicePlan ***Exclusive Dental Packages by Ameri-Dent***

Plan Effective Date: January 1, 2011

Presented By: Sample Broker
Sample Brokerage Firm



Dental Health Services



Vision Plan of
America



Madison National
Life Insurance Company
Independence Holding Group



TripleChoicePlan

DHMO (Prepaid) **Plan Options, Designs and Features**

Company Name

TripleChoicePlan - DHMO Plan Options

ADA CODES	COVERED SERVICES	** DHS DHMO DIAMOND (C3v) Co-payment	DHS DHMO GOLD (C2v) Co-payment	DHS DHMO EMERALD (554v) Co-payment	DHS DHMO SILVER (A2v) Co-payment	DHS DHMO BRONZE (222v) Co-payment	DHS DHMO RUBY (111v) Co-payment
	APPOINTMENTS						
	Office visit (in addition to other services)	\$ 4.00	\$ 4.00	\$ 4.00	\$ 4.00	\$ 4.00	\$ 4.00
	DIAGNOSTIC						
0210	X-rays, full mouth	No Charge	No Charge	No Charge	No Charge	No Charge	\$ 10.00
0220	X-rays, single film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
0230	X-rays, each additional film	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
1110	Adult	No Charge	No Charge	No Charge	No Charge	\$ 5.00	\$ 10.00
1120	Child	No Charge	No Charge	No Charge	No Charge	\$ 5.00	\$ 10.00
1351	Sealant - per tooth (permanent teeth to age 18)	No Charge	No Charge	No Charge	No Charge	\$ 5.00	\$ 10.00
	AMALGAM RESTORATIONS (Permanent Teeth)						
2140	Cavities involving - 1 tooth surface	No Charge	No Charge	\$ 3.00	\$ 10.00	\$ 18.00	\$ 25.00
2150	Cavities involving - 2 tooth surfaces	No Charge	No Charge	\$ 4.00	\$ 14.00	\$ 23.00	\$ 30.00
2160	Cavities involving - 3 tooth surfaces	No Charge	No Charge	\$ 6.00	\$ 17.00	\$ 28.00	\$ 35.00
	CROWNS, INLAYS, ONLAYS & POSTS						
2740	Porcelain Crown (not for Molars)	\$ 50.00	\$ 85.00	\$ 140.00	\$ 95.00	\$ 230.00	\$ 280.00
2751	Crown - porcelain fused to predominantly base metal	\$ 50.00	\$ 85.00	\$ 140.00	\$ 95.00	\$ 230.00	\$ 280.00
2930	Prefabricated stainless steel crown	\$ 10.00	\$ 20.00	\$ 30.00	\$ 50.00	\$ 50.00	\$ 60.00
2932	Prefabricated resin crown	\$ 10.00	\$ 20.00	\$ 30.00	\$ 50.00	\$ 50.00	\$ 60.00
2951	Pin retention-per tooth, in addition to restoration	No Charge	\$ 10.00	\$ 10.00	\$ 15.00	\$ 20.00	\$ 20.00
2952	Cast post and core	No Charge	\$ 20.00	\$ 50.00	\$ 50.00	\$ 60.00	\$ 70.00
2954	Prefab post and core	No Charge	\$ 20.00	\$ 45.00	\$ 45.00	\$ 55.00	\$ 55.00
	ENDODONTICS						
3110	Pulp cap - direct (excluding final restoration)	No Charge	\$ 2.00	\$ 5.00	\$ 10.00	No Charge	\$ 12.00
3220	Vital pulpotomy (excluding final restoration)	No Charge	\$ 7.00	\$ 10.00	\$ 15.00	No Charge	\$ 17.00
3310	Root canal treatment - (1 canal) anterior	\$ 20.00	\$ 55.00	\$ 45.00	\$ 90.00	\$ 145.00	\$ 150.00
3320	Root canal treatment - (1-2 canals) bicuspid	\$ 20.00	\$ 65.00	\$ 75.00	\$ 105.00	\$ 200.00	\$ 220.00
3330	Root canal treatment - (1-4 canals) molar	\$ 20.00	\$ 85.00	\$ 120.00	\$ 140.00	\$ 300.00	Not Listed
	PERIODONTICS						
4210	Gingivectomy/Gingivoplasty - per quad (3 or more teeth)	\$ 25.00	\$ 45.00	\$ 75.00	\$ 85.00	\$ 120.00	Not Listed
4341	Periodontal scaling/root planning - per quad	No Charge	\$ 2.00	\$ 35.00	\$ 15.00	\$ 40.00	\$ 50.00
4910	Periodontal maintenance procedures	No Charge	\$ 2.00	\$ 35.00	\$ 15.00	\$ 40.00	\$ 50.00

Company Name

TripleChoicePlan - DHMO Plan Options (cont.)

ADA CODES	COVERED SERVICES	** DHS DHMO DIAMOND (C3v) Co-payment	DHS DHMO GOLD (C2v) Co-payment	DHS DHMO EMERALD (554v) Co-payment	DHS DHMO SILVER (A2v) Co-payment	DHS DHMO BRONZE (222v) Co-payment	DHS DHMO RUBY (111v) Co-payment
DENTURES							
5110-20	Complete upper or lower denture	\$ 65.00	\$ 85.00	\$ 150.00	\$ 220.00	\$ 310.00	\$ 350.00
5211-12	Partial resin upper/lower, clasps and teeth	\$ 75.00	\$ 75.00	\$ 120.00	\$ 125.00	\$ 180.00	\$ 200.00
ADJUSTMENT, REPAIR AND RELINE DENTURE							
5410-22	Adjust denture or partial	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
5510	Repair broken complete denture base	\$ 5.00	\$ 15.00	\$ 30.00	\$ 25.00	\$ 30.00	\$ 30.00
5520	Replace missing/broken denture teeth (per tooth)	\$ 5.00	\$ 5.00	\$ 20.00	\$ 10.00	\$ 20.00	\$ 20.00
5630	Broken clasp, per clasp	No Charge	No Charge	\$ 40.00	\$ 10.00	\$ 40.00	\$ 40.00
5640	Broken teeth, per tooth	\$ 5.00	\$ 10.00	\$ 20.00	\$ 25.00	\$ 20.00	\$ 20.00
5650	Add tooth to existing partial, per tooth	\$ 5.00	\$ 6.00	\$ 20.00	\$ 15.00	\$ 20.00	\$ 20.00
5730-41	Reline (chairside)	\$ 10.00	\$ 25.00	\$ 30.00	\$ 55.00	\$ 70.00	\$ 80.00
5750-61	Reline (laboratory)	\$ 10.00	\$ 30.00	\$ 40.00	\$ 80.00	\$ 100.00	\$ 140.00
ORAL SURGERY							
7210	Surgical removal of an erupted tooth	\$ 5.00	\$ 5.00	\$ 20.00	\$ 35.00	\$ 75.00	\$ 100.00
7220	Soft tissue impaction	\$ 15.00	\$ 15.00	\$ 25.00	\$ 45.00	\$ 125.00	Not Listed
7230	Partially bony impaction	\$ 40.00	\$ 40.00	\$ 35.00	\$ 60.00	\$ 160.00	Not Listed
7240	Removal of impacted tooth - completely bony	\$ 40.00	\$ 40.00	\$ 50.00	\$ 60.00	\$ 200.00	Not Listed
7250	Surgical removal of residual tooth roots	\$ 5.00	\$ 5.00	\$ 25.00	\$ 35.00	\$ 120.00	Not Listed
7310	Alveoplasty in conjunction with extractions - per quad	No Charge	\$ 10.00	\$ 20.00	\$ 20.00	\$ 60.00	\$ 80.00
7510	Incision and drainage of abscess	No Charge	No Charge	No Charge	No Charge	\$ 5.00	\$ 10.00
9215	Local anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Employee		\$19.95	\$13.70	\$12.25	\$11.70	\$8.85	\$5.95
Employee + Spouse		\$39.15	\$28.45	\$24.35	\$22.70	\$18.60	\$9.95
EE +Child(ren)		\$38.25	\$27.05	\$23.10	\$21.60	\$17.60	\$9.50
Family		\$58.60	\$39.65	\$34.65	\$32.45	\$26.80	\$13.95

Plan Effective Date: January 1, 2011

Rates Guaranteed for: 24 Months

- Please note:**
1. Minimum 25 Employees must enroll in the Diamond Plan for it to be offered.**
 2. Up to 3 DHMO Plan Designs may be selected per installation.
 3. Network locations can be found at www.dentalhealthservices.com

4. All DHMO Plans include Orthodontia.
5. Optional Vision add \$4.25 per tier.
6. DHMO Plans are available in California Only.

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Exclusive Dental Packages by Ameri-Dent



DENTAL HEALTH SERVICES

Orthodontia Coverage

(Included with the DHMO Dental and may be selected as an option for the PPO/EPO Dental)

Member Pays

Consultation Fee -- Adults & Children	\$25.00
Full banded/Full treatment (Adults, Age 19 and over) *(Not including x-rays or models)	\$1975.00
Full banded/Full treatment (Children up through age 18) *(Not including x-rays or models)	\$1775.00
Retainers (after ortho)	\$180.00
Broken Appointments (without 24-hour notice)	\$25.00

Please call Dental Health Services for referral to an associated orthodontist nearest you.

LIMITATIONS: (The following are subject to additional charges)

- A. CEPHALOMETRIC x-rays, dental x-rays. *
- B. TRACINGS and photographs.
- C. STUDY models. *
- D. REPLACEMENT of lost or broken appliances.
- E. CHANGES in treatment necessitated by an accident of any kind.
- F. MALOCCLUSIONS so severe or mutilated which are not amenable to ideal orthodontic therapy.
- G. RETREATMENT of orthodontic cases.
- H. ANY dental procedures considered to be within the field of general dentistry including but not limited to:
 - 1. MYOFUNCTIONAL therapy.
 - 2. GENERAL anesthetics including intravenous and inhalation sedation.
 - 3. DENTAL services of any nature performed in a hospital.

EXCLUSIONS:

- A. TREATMENT of a case in progress at inception of eligibility.
- B. SURGICAL procedures (including extraction of teeth) incidental to orthodontic treatment.
- C. SURGICAL procedures related to cleft palate, micrognathia or macrognathia.
- D. TREATMENT related to temporomandibular joint disturbances and/or hormonal imbalances.

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EPO / PPO

Plan Options, Designs and Features

Company Name

TripleChoicePlan - EPO/PPO Plan Options

COVERED BENEFITS	California EPO A (In-Network Only)	California EPO B (In-Network Only)	California EPO C (In-Network Only)	California PPO 1 (In/Out)	California PPO 2 (In/Out)	California PPO 3 (In/Out)
PREVENTIVE / DIAGNOSTIC (includes exams, cleanings, x-rays)	100%	100%	100%	100%/100%	100%/100%	100%/80%
BASIC (includes perio, endo, oral surgery)	90%	80%	80%	90%/80%	80%/80%	80%/80%
MAJOR (includes crowns, bridges, perio surgical, implants and dentures)	60%	50%	50%	60%/50%	50%/50%	50%/50%
ORTHODONTIA	Optional (see below)					
ENDODONTIC / PERIODONTIC	Basic**	Basic**	Basic**	Basic**	Basic**	Basic**
ANNUAL MAXIMUM	\$2,000	\$1,500	\$1,000	\$2,000	\$1,500	\$1,000
DEDUCTIBLE - IN NETWORK	\$50 (\$150 max)	\$50 (\$150 max)	\$50 (\$150 max)	\$50 (\$150 max)	\$50 (\$150 max)	\$50 (\$150 max)
DEDUCTIBLE - OUT OF NETWORK (Deductibles waived for preventive/diagnostic services)	N/A	N/A	N/A	\$50 (\$150 max)	\$50 (\$150 max)	\$100 (\$300 max)
OUT OF NETWORK CLAIMS PAID AT:	N/A	N/A	N/A	80th	80th	80th
WAITING PERIODS	None*	None*	None*	None*	None*	None*

PREMIUMS

Employee only
Employee + Spouse
Employee + Child(ren)
Family

Plan Effective Date: January 1, 2011

Rates Guaranteed for: 12 or 24 Months

OPTIONAL ADULT / CHILD ORTHODONTIC & VISION BENEFIT			
	Vision Plan	Prepaid Ortho	PPO Ortho \$1000
Employee only	\$4.25	\$1.25	
Employee + Spouse	\$4.25	\$1.25	
Employee + Child(ren)	\$4.25	\$1.25	
Family	\$4.25	\$1.25	

*Waiting period waived at initial group enrollment if group has prior coverage. No waiting periods assumes a minimum of 40% participation of eligible employees. If 40% participation is not attained, a 6 month wait on Basic and 12 month wait on Major applies

**Periodontal Surgical procedures are classified and paid as Major Benefits

Requires a minimum of 5 employees to be enrolled at all times on either the PPO or EPO plan.
In-Network Benefits available through the First Dental Health network in California (www.firstdentalhealth.com).
In-Network Benefits available through the Dentemax network in Nationally (www.dentemax.com).

TripleChoicePlan

Exclusive Dental Packages by Ameri-Dent

PPO Ortho Plan

- **Benefit covers 50% of the cost of orthodontic procedures**
- **Members have the option of visiting any orthodontist they choose**
- **No Deductible**
- **Lifetime Maximum available in \$1000, \$1500, and \$2000 options**
- **Annual Maximum is 50% of Lifetime Maximum***



Security Life

*This amount may be reduced for members who have had previous orthodontic coverage. Ask for more details.

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Vision Plan Options **Description of Benefits / Co-payments**

Company Name

TripleChoicePlan - Vision Plan Option



VISION PLAN OF AMERICA

M-Plus - Description of Benefits / Co-payment (Unlimited Usage)

Member Services

Preventive Eye Care Analysis	
Cataract Analysis	
Glaucoma Test (IOP Measurement)	
Frame Repairs - screw, nose pad replacement	
Frame Adjustments	
Tint #1, (solid color) plastic lenses	
Computerized vision analysis (where available)	
Frames	25% Off UCR
Refraction* (see Note # 1) - Determines Glasses Prescription	\$36
Lenses (CR-39)	(See Note #2 & #3)
Single Vision Lenses	\$42
Bifocal Lenses (Rnd. 22 – FT 22-28)	\$55
Trifocal Lenses (FT 7X22)	\$79
Progressive (Generic)	\$139
Progressive (Premium)	20% Off UCR
Lenticular Lenses (S.V.)	\$180
Lenticular Lenses (B.F.)	\$240
Lens Extras: (Add to lens cost)	
Oversize (over 58mm E.D.)	\$15
Fashion Tints (each color, CR-39)	
Single gradient	\$15
Double gradient	\$25
Photoxtra (S/V)	20% Off UCR
Photoxtra (B/F)	20% Off UCR
Photoxtra (Progressive)	20% Off UCR
Photochromic (i.e. transiti 20% Off UCR)	20% Off UCR

ALL LENS PRICES ARE PER PAIR

Members Pays

No Charge
No Charge
No Charge
No Charge
No Charge
No Charge
No Charge
25% Off UCR
\$36
(See Note #2 & #3)
\$42
\$55
\$79
\$139
20% Off UCR
\$180
\$240
\$15
\$15
\$25
20% Off UCR
20% Off UCR
20% Off UCR
20% Off UCR

Member Services

Contact Lenses (see Note #4)	
Contact Lens Evaluation & Fitting	25% Off UCR
Contact Lens Service Agr	Normal Retail Price
Contact Lens Care Kits	Normal Retail Price
Additional C.L. Visits (each)	\$10
Hard Lenses (PMMA)	\$85
R.G.P. (Sphere)	\$145
Soft (Daily):	
Bausch & Lomb (or similar)	\$90
Cooper (or similar)	\$99
Soft (Extended Wear):	
Bausch & Lomb (or similar)	\$90
Ciba (or similar)	\$99
Toric Contact Lenses:	
Soft...Hard...R.G.P.	20% off UCR
Soft Custom Colors for Cosmetic	
Eye Color Changes	20% off UCR
Disposable (1 st 3 months supply only)	20% off UCR
Custom Contact Lenses (see note #5)	20% off UCR
(Orthokeratology, CRT)	Not Covered
Multifocal Contact Lenses	10% off UCR
(Soft Disposable 1 st 3 months supply only)	
Scratchcote (Plastic lenses)	\$20
Polycarbonate	\$39
Thin Lens (other than polycarbonate)	20% Off UCR
UV Coating	\$10
Rimless (Edge Groove or 20% Off UCR)	20% Off UCR
Prism	\$4.00 per Diopter

ANY PROCEDURE OR LENS NOT LISTED AND PROVIDED BY THE SELECTE OPTOMETRIST IS AVAILABLE ON A FEE-FOR-SERVICE BASIS.

Note # 1- Refraction determines the need for prescription. The \$36 co-payment must be paid directly to the doctor at the time of service. These benefits are part of and used in conjunction with your HMO package.

Note # 2- Cost of lenses may have an additional charge when power of lenses exceeds ±6.00 D SPH or when combined with ±2.00 D CYL.

Note # 3- Any multifocal add of +3.25 or more may be charged a laboratory per pair. SEGS larger than 28mm may be charged an added laboratory fee per pair. Glass lenses may have an additional charge.

Note # 4- When purchasing contact lenses you may require a contact lens evaluation in addition to a refraction.

Note # 5- Contact lens powers over ±6.25 SPH and/or ±2.0 D CYL (combined) are considered custom, and will be charged extra. Medically necessary

LASIK VISION - VPA is now providing members ACCESS TO a Laser Vision Correction preferred pricing program included at no additional cost! Savings from 40-55% off the national average charge. Experienced Board Certified Ophthalmologists. Flexible financing available.



The Camden Insurance Agency

An affiliate of Vision Plan of America

**Advantage +
PPO Vision Plan**

**High Option
TripleChoicePlan**

Camden Advantage Plus Benefit Frequency & Plan Design

	<u>EXAMINATION</u>	<u>SPECTACLE LENSES</u>	<u>FRAME</u>	<u>CONTACT LENSES</u>
PLANS A, B & C	12	12 or 24 months	12 or 24 months	12 or 24 months

Advantage Plus Schedule of Benefits

	<u>IN-NETWORK</u>	<u>OUT-OF-NETWORK</u>
<u>EYE EXAMINATION</u>	Covered in full*	Reimbursed up to \$45.00
<u>Spectacle Lenses (pair)</u>		
-Standard Single Vision	Covered in full*	Reimbursed up to \$35.00
-Standard Bifocal	Covered in full*	Reimbursed up to \$45.00
-Standard Trifocal	Covered in full*	Reimbursed up to \$55.00
-Standard Lenticular	Covered in full*	Reimbursed up to \$120.00
-Progressive	20% off U&C, minus \$50 allowance* *after the stipulated co payment.	Reimbursed up to \$45.00
<u>Lens Options</u>	Preferred Pricing (20% off retail)	Reimbursed up to \$0.00
<u>Frame</u>	\$50 wholesale allowance (approx. retail of \$100 to \$150) *	Reimbursed up to \$40.00
<u>Contact Lenses</u>	<i>(In lieu of frame and spectacle lenses)</i>	
-Elective	\$130 allowance	Reimbursed up to \$130.00
-Medically Necessary	Covered in full(with prior authorization)	Reimbursed up to \$250.00
<u>LASIK Refractive Surgery Benefits</u>	<i>In lieu of all other services for one benefit year. This is a one-time, lifetime allowance.</i> In Network Provider discount up to 25% plus \$150 allowance	Reimbursed up to \$150.00

Plan Highlights

- ✓ Various Co Payment options available.
- ✓ National Provider Network available now including COSTCO
- ✓ Cosmetic Contact Lens allowance up to \$130 (In & Out of Network)
- ✓ Medically Necessary Contact Lenses covered in full with prior authorization (In Network)
- ✓ LASIK Refractive Surgery at Discounted Rates
- ✓ Mail Order Contact Lenses at Discounted Rates
- ✓ Progressive Lens benefit included
- ✓ Specialty Lens benefit included
- ✓ 20% Off Lens Extras (Tints, Scratch Coat, Anti-Reflective Coat, etc.)
- ✓ 20% Off Additional Eyewear
- ✓ Member Website Allows – Printing Replacement ID Cards, Verifying Eligibility, Searching for a Provider, Reviewing Plan Designs, Printing Claim Forms

Participation Requirements

- Policies and rates are guaranteed for two (2) years
- Employees enrolling in the VOLUNTARY group plan must maintain a minimum enrollment level of ten (10) lives and agree to remain enrolled during the designated plan period.
- Employees enrolling in the EMPLOYER SPONSORED group plan must maintain a minimum group size & participation of five (5) eligible employees. Groups with fewer than ten (10) eligible employees will be required to maintain eligibility and receive a monthly bill via On-line E-billing & Eligibility Maintenance Program.
- Employer sponsored plans assume a 75% employer contribution. And 100% participation.
- An employer contribution level of 50% is accepted if the benefits are tied to medical plan participation.

Advantage + PPO Vision Plan
Employer Sponsored Plan Rates
For Groups of 5+

PLAN A (12/12/12/12)	\$0 –EXAM	\$10 –EXAM	\$10 –EXAM	\$10-EXAM	\$10-EXAM
ANNUAL CO-PAY’S:	\$0-MATERIALS	\$0-MATERIALS	\$10-MATERIALS	\$15-MATERIALS	\$25-MATERIALS
<i>Employee Only</i>	\$9.45	\$8.79	\$8.39	\$8.19	\$7.77
<i>Employee + Spouse</i>	\$16.55	\$15.39	\$14.68	\$14.32	\$13.61
<i>Employee+ch(ren)</i>	\$19.85	\$18.41	\$17.61	\$17.19	\$16.33
<i>Employee + Family</i>	\$24.59	\$22.87	\$21.80	\$21.28	\$20.21

PLAN B (12/12/24/12)	\$0 –EXAM	\$10 –EXAM	\$10 –EXAM	\$10-EXAM	\$10-EXAM
ANNUAL CO-PAY’S:	\$0-MATERIALS	\$0-MATERIALS	\$10-MATERIALS	\$15-MATERIALS	\$25-MATERIALS
<i>Employee Only</i>	\$8.15	\$7.59	\$7.23	\$7.05	\$6.71
<i>Employee + Spouse</i>	\$14.27	\$13.27	\$12.65	\$12.35	\$11.73
<i>Employee+ch(ren)</i>	\$17.21	\$15.92	\$15.19	\$14.81	\$14.08
<i>Employee + Family</i>	\$21.19	\$19.71	\$18.80	\$18.35	\$17.43

PLAN C (12/24/24/24)	\$0 –EXAM	\$10 –EXAM	\$10 –EXAM	\$10-EXAM
ANNUAL CO-PAY’S:	\$0-MATERIALS	\$0-MATERIALS	\$10-MATERIALS	\$20-MATERIALS
<i>Employee Only</i>	\$7.57	\$7.05	\$6.73	\$6.40
<i>Employee + Spouse</i>	\$13.27	\$12.33	\$11.76	\$11.20
<i>Employee+ch(ren)</i>	\$15.92	\$14.80	\$14.12	\$13.44
<i>Employee + Family</i>	\$19.71	\$18.33	\$17.48	\$16.63

Voluntary Group Rates
For Groups of 10+

PLAN A (12/12/12/12)	\$0 –EXAM	\$10 –EXAM	\$10 –EXAM	\$10-EXAM	\$10-EXAM
ANNUAL CO-PAY’S:	\$0-MATERIALS	\$0-MATERIALS	\$10-MATERIALS	\$15-MATERIALS	\$25-MATERIALS
<i>Employee Only</i>	\$12.51	\$11.63	\$11.09	\$10.83	\$10.28
<i>Employee + Spouse</i>	\$23.63	\$21.97	\$20.96	\$20.45	\$19.44
<i>Employee+ch(ren)</i>	\$25.76	\$23.96	\$22.84	\$22.29	\$21.59
<i>Employee + Family</i>	\$33.13	\$30.81	\$29.39	\$28.68	\$27.25

PLAN B (12/12/24/12)	\$0 –EXAM	\$10 –EXAM	\$10 –EXAM	\$10-EXAM	\$10-EXAM
ANNUAL CO-PAY’S:	\$0-MATERIALS	\$0-MATERIALS	\$10-MATERIALS	\$15-MATERIALS	\$25-MATERIALS
<i>Employee Only</i>	\$10.77	\$10.03	\$9.56	\$9.33	\$8.87
<i>Employee + Spouse</i>	\$20.37	\$18.95	\$18.07	\$17.63	\$16.76
<i>Employee+ch(ren)</i>	\$22.20	\$20.65	\$19.69	\$19.21	\$18.21
<i>Employee + Family</i>	\$28.56	\$26.56	\$25.35	\$24.72	\$23.49

PLAN C (12/24/24/24)	\$0 –EXAM	\$10 –EXAM	\$10 –EXAM	\$10-EXAM
ANNUAL CO-PAY’S:	\$0-MATERIALS	\$0-MATERIALS	\$10-MATERIALS	\$20-MATERIALS
<i>Employee Only</i>	\$10.03	\$9.32	\$8.89	\$8.47
<i>Employee + Spouse</i>	\$18.55	\$17.63	\$16.80	\$15.78
<i>Employee+ch(ren)</i>	\$20.65	\$19.20	\$18.32	\$17.43
<i>Employee + Family</i>	\$26.56	\$24.71	\$23.56	\$22.41

Additional plan designs and co payments are available upon request.