

**CALIFORNIA'S VALUED TRUST
PPO HEALTH PLANS
2009 / 2010**

BENEFIT	PPO PLAN 1	PPO PLAN 2	PPO PLAN 3	PPO PLAN 4	PPO PLAN 5	PPO PLAN 6	PPO PLAN 7	PPO PLAN 8	PPO PLAN 9	PPO PLAN 10	
MAJOR MEDICAL*	Deductible: 0 Coinsurance: 100%	Deductible: 0 Coinsurance: 100%	Deductible: \$100 Ind / \$300 family Coinsurance: 100% Out-of-Pocket Max: Deductible	Deductible: \$100 Ind / \$300 family Coinsurance: 90/10 Out-of-Pocket Max: \$300 per person + deduct.	Deductible: \$100 Ind / \$300 family Coinsurance: 90/10 Out-of-Pocket Max: \$300 per person + deduct	Deductible: \$250 Ind / \$750 family Coinsurance: 80/20 Out-of-Pocket Max: \$1,000 per person + deduct	Deductible: \$250 Ind / \$750 family Coinsurance: 80/20 Out-of-Pocket Max: \$1,000 per person + deduct	Deductible: \$500 Ind / \$1,500 family Coinsurance: 80/20 Out-of-Pocket Max: \$2,000 per person + deduct	Deductible: \$1,000 Ind / \$3,000 family Coinsurance: 80/20 Out-of-Pocket Max: \$3,000 per person + deduct	Deductible: \$2,000 Ind / \$6,000 family Coinsurance: 80/20 Out-of-Pocket Max: \$4,000 per person + deduct	
LIFETIME MAX PER PERSON	\$5,000,000										
DOCTOR VISITS	Paid at 100% Par Rate to Preferred Providers	\$10 copay	\$10 copay (copay not applied to deductible)	\$10 copay (copay not applied to deductible or out-of-pocket max)	\$20 copay (copay not applied to deductible or out-of-pocket max)	\$10 copay (copay not applied to deductible or out-of-pocket max)	\$20 copay (copay not applied to deductible or out-of-pocket max)	Major Medical*			
ANNUAL PHYSICAL	Up to \$200/year for employee and spouse; balance to Major Med*										
IMMUNIZATIONS	Employee & spouse covered under annual physical allowance. Paid at 100% Par Rate to Preferred Providers for covered dependent children.		Major Medical* Employee & spouse covered under annual physical allowance.								
PREVENTIVE CARE FOR CHILDREN	Paid at 100% Par Rate to Preferred Providers. Covered, as long as eligible		Major Medical* Covered, as long as eligible								
WELL WOMAN: PAP SMEAR/ MAMMOGRAM	Paid at 100% Par Rate to Preferred Providers.		Major Medical*								
OUTPATIENT X-RAY & LAB	Paid at 100% Par Rate to Preferred Providers		Major Medical*								
PHYSICAL THERAPY	Paid at 100% Par Rate to Preferred Providers. Non-Par Providers limited to a combined max of 13 visits per year, max \$25 per visit	Paid at 100% Par Rate to Preferred Providers. (Copay, if applicable.) Non-Par Providers limited to a combined max of 13 visits per yr, max \$25 per visit.	Major Medical* (Copay, if applicable.) Non-Par Providers limited to a combined max of 13 visits per year, max \$25 per visit.					Major Medical* Non-Par Providers limited to a combined max of 13 visits per year, max \$25 per visit.			

Page 2	PPO PLAN 1	PPO PLAN 2	PPO PLAN 3	PPO PLAN 4	PPO PLAN 5	PPO PLAN 6	PPO PLAN 7	PPO PLAN 8	PPO PLAN 9	PPO PLAN 10
CHIROPRACTIC	Paid at 100% Par Rate to Prefrd Providers Non-Par Providers limited to a combined max of 13 visits per year, max \$25 per visit.	Paid at 100% Par Rate to Prefrd Providers (Copay, if applicable) Non-Par Providers limited to a combined max of 13 visits per year, max \$25 per visit.	Major Medical* (Copay, if applicable.) Non-Par Providers limited to a combined max of 13 visits per year, max \$25 per visit.				Major Medical* Non-Par Providers limited to a combined max of 13 visits per year, max \$25 per visit.			
ACUPUNCTURE	Paid at 100% Par Rate to Preferred Providers. Maximum of 12 visits per calendar year	Paid at 100% Par Rate to Pref Providers (Copay, if applicable) Max of 12 visits per calendar year	Major Medical* (Copay, if applicable) Maximum of 12 visits per calendar year				Major Medical* Maximum of 12 visits per calendar year			
HOSPITAL INPATIENT	Paid at 100% Par Rate to Preferred Providers; Unlimited days; Semi private room		Major Medical* Unlimited days, semi-private room							
HOSPITAL EMERGENCY ROOM	\$35 copay (copay waived if admitted as in-patient)		\$35 copay Major Medical* (copay not applied to deductible or out-of-pocket max and waived if admitted as in-patient)							
RADIATION, CHEMO, & SURGERY	Paid at 100% Par Rate to Preferred Providers		Major Medical*							
HOME HEALTH CARE	Paid at 100% Par Rate to Preferred Providers Limited to 100 visits per calendar		Major Medical* Limited to 100 visits per calendar year							
HOSPICE	100% of Covered Expense with a lifetime max of \$10,000									
DURABLE MEDICAL EQUIPMENT	Paid at 100% Par Rate to Preferred Providers		Major Medical*							
AMBULANCE-GROUND/AIR	100% of covered charges		Major Medical*							
MENTAL HEALTH INPATIENT	Facility charges paid at 80% to Preferred Providers up to a max of 30 days per calendar year.		After deductible met, facility charges paid at 80% to Preferred Providers up to a max of 30 days per calendar year.							
MENTAL HEALTH & SUBSTANCE ABUSE PROFESSIONAL CHARGES (INPATIENT / OUTPATIENT)	50% up to a max of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance Abuse Limited to 50 Visits Per Year)		After deductible met, 50% up to a max of \$50 per visit to Preferred Providers & up to \$25 to Non-Par Providers. (Substance Abuse Limited to 50 Visits Per Year)							
SUBSTANCE ABUSE INPATIENT	\$300 Copay – After copay met, MHN Provider 100%, Non-Par – 50%. Two Courses of Treatment during lifetime									

Major Medical* - Deductible and coinsurance apply. Non-par (non-participating) providers receive payments based on the non-participating fee allowance and are subject to the deductibles and coinsurance of the plan. **ALL PERCENTAGES ARE BASED ON PROVIDERS PAYMENTS TO PREFERRED HOSPITALS, PHYSICIANS AND OTHER NETWORK PROVIDERS. THIS SUMMARY IS FOR COMPARISON PURPOSES ONLY. PLEASE REFER TO THE ACTUAL SUMMARY PLAN DESCRIPTION FOR COMPLETE BENEFITS.**