

**CALIFORNIA'S VALUED TRUST
PPO HEALTH PLANS
2011 / 2012**

| 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: \$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: \$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 | |
| CALENDAR YEAR MAXIMUM PER PERSON | \$5,000,000 | | | | | | | | | | |
| DOCTOR VISITS | \$10 Copay | \$20 Copay | \$20 Copay (Copay not applied to deduct.) | \$20 Copay (Copay not applied to deduct. or out-of-pocket max) | \$30 Copay (Copay not applied to deduct. or out-of-pocket max) | \$20 Copay (Copay not applied to deduct. or out-of-pocket max) | \$30 Copay (Copay not applied to deduct. or out-of-pocket max) | Major Medical* | | | |
| IMMUNIZATIONS | Paid at 100%** | | | | | | | | | | |
| PREVENTIVE CARE FOR CHILDREN | Paid at 100%** Covered, as long as eligible. | | | | | | | | | | |
| PREVENTIVE CARE FOR ADULTS | Paid at 100%** | | | | | | | | | | |
| OUTPATIENT X-RAY & LAB | Paid at 100%** | | Major Medical* | | | | | | | | |
| RADIATION / CHEMO | Paid at 100%** | | Major Medical* | | | | | | | | |
| DURABLE MEDICAL EQUIPMENT | Paid at 100%** | | Major Medical* | | | | | | | | |
| AMBULANCE-GROUND/AIR | 100%** of covered charges | | Major Medical* | | | | | | | | |
| PHYSICAL THERAPY | Paid at 100%** Par Rate to Preferred Providers. (Copay, if applicable.) Non-Par Providers limited to a combined maximum of 13 visits per year. | | Major Medical* (Copay, if applicable.) Non-Par Providers limited to a combined maximum of 13 visits per year. | | | | Major Medical* Non-Par Providers limited to a combined maximum of 13 visits per year. | | | | |

| 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 Preferred Providers (Copay, if applicable) Non-Par Providers limited to a combined maximum of 13 visits per year. | Major Medical* (Copay, if applicable.) Non-Par Providers limited to a combined maximum of 13 visits per year. | | | | | Major Medical* Non-Par Providers limited to a combined maximum of 13 visits per year. | | | |
| ACUPUNCTURE | Paid at 100%** Par Rate to Preferred Providers (Copay, if applicable) Maximum 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%** Unlimited days; Semi private room | Major Medical* Unlimited days, semi-private room | | | | | | | | |
| HOSPITAL EMERGENCY ROOM | \$75 Copay (Copay waived if admitted as in-patient) | \$75 Copay Major Medical* (Copay not applied to deductible and waived if admitted as in-patient) | \$75 Copay Major Medical* (Copay not applied to deductible or out-of-pocket maximum and waived if admitted as in-patient) | | | | | | | |
| HOME HEALTH CARE | Paid at 100%** Limited to 100 visits per calendar year | Major Medical* Limited to 100 visits per calendar year | | | | | | | | |
| HOSPICE | 100%** of Covered Expense | | | | | | | | | |

* **Major Medical** - Deductible and coinsurance apply.

****Explanation of Covered Expense:**

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following: **PPO Providers** - PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount. **Non-PPO Providers** - For non-emergency services, the scheduled amount. For emergency services, same as other health care providers. **Other Health Care Providers** (includes those not represented in the PPO provider network) - The customary & reasonable charge for professional services or the reasonable charge for institutional services. **When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense and actual charges, as well as any deductible & percentage Copay.** All percentages are based on payments to preferred hospitals, physicians and other network providers.

Effective 10/1/11: 24/7 NURSELINE

This summary is for comparison purposes only. Please refer to the actual benefit booklet for complete benefits.