**ENVIRONMENTAL BUILDING**
**Effective: December 1, 2015**

| | | |
|---|---|---|
| Your Current Plan is: | | |
| Your Current Coverage and Cost: | Employee Only | $ |
| Your Current Coverage Renews at: | Employee Only | NA |

# Renewal Enrollment Worksheet (1 of 9)

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *after* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has selected the **Gold Tier** and has agreed to contribute:
100 % of the Lowest Cost Employee Rate for **Kaiser Permanente HMO B**
100 % of the Dependent Rate for Same Plan as Above

## Gold/Silver Plan Options & Rates

### HMO Benefit Plans

| # | Health Plan | Type | Plan Name | Network | Monthly Premiums prior to Employer Contribution: Employee Only | Your Cost per Pay Period: Employee Only |
|---|---|---|---|---|---|---|
| 1 | KAISER PERMANENTE | HSA/HMO | SILVER HMO A | FULL | $ 288.12 | $ 0.00 |
| 2 | KAISER PERMANENTE | HMO | SILVER HMO C | FULL | $ 299.95 | $ 0.00 |
| 3 | KAISER PERMANENTE | HMO | SILVER HMO B | FULL | $ 306.77 | $ 0.00 |
| 4 | ANTHEM BLUE CROSS | HMO | SILVER HMO A | SELECT HMO | $ 313.07 | $ 0.00 |
| 5 | UNITEDHEALTHCARE | HMO | SILVER HMO D | FOCUS | $ 315.65 | $ 0.00 |
| 6 | SUTTER HEALTH PLUS | HSA/HMO | SILVER HMO C | FULL | $ 316.71 | $ 0.00 |
| 7 | SUTTER HEALTH PLUS | HSA/HMO | SILVER HMO D | FULL | $ 323.58 | $ 0.00 |
| 8 | SUTTER HEALTH PLUS | HMO | SILVER HMO A | FULL | $ 331.60 | $ 0.00 |
| 9 | SUTTER HEALTH PLUS | HMO | SILVER HMO B | FULL | $ 335.25 | $ 0.00 |
| 10 | KAISER PERMANENTE | HMO | GOLD HMO A | FULL | $ 350.25 | $ 0.00 |
| 11 | KAISER PERMANENTE | HMO | GOLD HMO B | FULL | $ 357.66 | $ 0.00 |
| 12 | ANTHEM BLUE CROSS | HMO | GOLD HMO A | SELECT HMO | $ 359.29 | $ 1.63 |
| 13 | ANTHEM BLUE CROSS | HMO | GOLD HMO B | SELECT HMO | $ 368.41 | $ 10.75 |
| 14 | UNITEDHEALTHCARE | HMO | GOLD HMO C | FOCUS | $ 370.40 | $ 12.74 |
| 15 | AETNA | HMO | SILVER HMO B | BASIC HMO | $ 377.62 | $ 19.96 |
| 16 | SUTTER HEALTH PLUS | HMO | GOLD HMO A | FULL | $ 379.71 | $ 22.05 |
| 17 | SUTTER HEALTH PLUS | HMO | GOLD HMO C | FULL | $ 394.44 | $ 36.78 |
| 18 | SUTTER HEALTH PLUS | HMO | GOLD HMO B | FULL | $ 399.45 | $ 41.79 |
| 19 | HEALTH NET | HMO | GOLD HMO B | WHOLECARE | $ 412.89 | $ 55.23 |
| 20 | AETNA | HMO | SILVER HMO A | HMO DEDUCTIBLE | $ 417.60 | $ 59.94 |
| 21 | HEALTH NET | HMO | GOLD HMO A | WHOLECARE | $ 437.49 | $ 79.83 |
| 22 | AETNA | HMO | GOLD HMO B | AETNA VALUE NETW | $ 456.40 | $ 98.74 |
| 23 | AETNA | HMO | GOLD HMO A | AETNA VALUE NETW | $ 460.66 | $ 103.00 |
| 24 | UNITEDHEALTHCARE | HMO | SILVER HMO A | SIGNATUREVALUE | $ 462.15 | $ 104.49 |
| 25 | UNITEDHEALTHCARE | HMO | GOLD HMO A | SIGNATUREVALUE | $ 542.29 | $ 184.63 |

## Gold/Silver Plan Options & Rates

### EPO Benefit Plans

| # | Health Plan | Type | Plan Name | Network | Monthly Premiums prior to Employer Contribution: Employee Only | Your Cost per Pay Period: Employee Only |
|---|---|---|---|---|---|---|
| 26 | ANTHEM BLUE CROSS | EPO | SILVER EPO A | PRUDENT BUYER | $ 458.19 | $ 100.53 |
| 27 | ANTHEM BLUE CROSS | HSA/EPO | GOLD EPO A | PRUDENT BUYER | $ 505.79 | $ 148.13 |

## Gold/Silver Plan Options & Rates

### PPO Benefit Plans

| # | Health Plan | Type | Plan Name | Network | Monthly Premiums prior to Employer Contribution: Employee Only | Your Cost per Pay Period: Employee Only |
|---|---|---|---|---|---|---|
| 28 | HEALTH NET | PPO | SILVER PPO A | FULL | $ 428.83 | $ 71.17 |
| 29 | HEALTH NET | PPO | SILVER PPO B | FULL | $ 434.47 | $ 76.81 |
| 30 | ANTHEM BLUE CROSS | PPO | SILVER PPO B | SELECT PPO | $ 462.96 | $ 105.30 |
| 31 | ANTHEM BLUE CROSS | PPO | SILVER PPO A | ADVANTAGE PPO | $ 463.66 | $ 106.00 |
| 32 | HEALTH NET | PPO | GOLD PPO A | FULL | $ 474.36 | $ 116.70 |
| 33 | HEALTH NET | PPO | GOLD PPO B | FULL | $ 480.00 | $ 122.34 |
| 34 | ANTHEM BLUE CROSS | PPO | GOLD PPO D | SELECT PPO | $ 515.66 | $ 158.00 |
| 35 | ANTHEM BLUE CROSS | PPO | GOLD PPO B | SELECT PPO | $ 523.77 | $ 166.11 |
| 36 | ANTHEM BLUE CROSS | PPO | GOLD PPO C | SELECT PPO | $ 534.72 | $ 177.06 |

# ENVIRONMENTAL BUILDING
**Effective: December 1, 2015**

| Your Current Plan is: | | |
|---|---|---|
| Your Current Coverage and Cost: | Employee Only | $ |
| Your Current Coverage Renews at: | Employee Only | NA |

## Renewal Enrollment Worksheet (2 of 9)

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *after* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

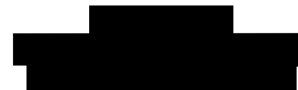
Your Employer has selected the **Gold Tier** and has agreed to contribute:
100 % of the Lowest Cost Employee Rate for **Kaiser Permanente HMO B**
100 % of the Dependent Rate for Same Plan as Above

| | Health Plan | Type | Plan Name | Network | Employee Only | Employee Only |
|---|---|---|---|---|---|---|
| 37 | ANTHEM BLUE CROSS | PPO | GOLD PPO A | ADVANTAGE PPO | $ 555.21 | $ 197.55 |

Note: Rates are guaranteed for 12 months unless your employer group has an address change into a new rating area during the year. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/documents/) for additional benefits.

# Employee Enrollment Worksheet - Dental

**ENVIRONMENTAL BUILDING STRATEGIES**
Quote #: **000129197.007**
Employer Zip Code: 94111



All DHMO Dental benefits are covered In-Network only.

| DeltaCare® USA | HMO Silver | HMO Gold |
|---|---|---|
| **Exams and Diagnostics** | | |
| Annual Maximum | None | None |
| Annual Deductible | None | None |
| Initial Oral Exam | 100% | 100% |
| Periodic Oral Exam | 100% | 100% |
| Teeth Cleaning | 100% | 100% |
| Bite Wing X-Ray | 100% | 100% |
| **Restorative** | | |
| Cavities-Amalgam, 1 Surface | $5 | 100% |
| Cavities-Amalgam, 2 Surfaces | $10 | 100% |
| **Crowns** | | |
| Porcelain-Base Metal (posterior) | $195 | $140 |
| Full Cast Noble Metal | $200 | $150 |
| **Periodontics** | | |
| Gingivectomy-Per Tooth | $80 | $80 |
| Periodontal Scaling and Root Planing (quadrant) | $30 | $20 |
| **Endodontics** | | |
| Single Root Canal | $85 | $55 |
| Bi-Root Canal | $150 | $120 |
| Molar Root Canal | $280 | $250 |
| **Waiting Periods** | None | None |
| **Oral Surgery** | | |
| Removal of Uncomplicated Single Tooth | $5 | 100% |
| Removal of Impacted Tooth - Partially Bony | $75 | $70 |
| Removal of Impacted Tooth - Completely Bony | $95 | $90 |
| **Orthodontics** | | |
| Children (maximum age 18) | $1,700 | $1,700 |
| Adult | $1,900 | $1,900 |
| **Prosthodontics** | | |
| Complete Upper or Lower Denture | $215 | $145 |
| Partial Upper or Lower Denture | $180 | $120 |

Note: Copays listed are for services performed by general dentists. Please consult the EOC for specialist copays.

| Delta Dental FFS | PPO Gold | PPO Platinum |
|---|---|---|
| **In-Network** | | |
| Annual Maximum | $1,500 | $2,000 |
| Annual Deductible | $50 | $50 |
| Preventive Care | Ded. Waived | Ded. Waived |
| Preventive | 100% | 100% |
| Basic | 80% | 80% |
| Major | 50% | 50% |
| Endo & Periodontics | 80% | 80% |
| Restorative | See EOC | See EOC |
| Waiting Period Basic | None | None |
| Waiting Period Major | None | None |
| Orthodontia Adult | Not Available | Not Available |
| Orthodontia Children (maximum age 18) | Not Available | Not Available |
| Waiting Period Ortho | None | None |
| **Out-of-Network** | | |
| Annual Maximum | $1,500 | $2,000 |
| Annual Deductible | $50 | $50 |
| Preventive Care | Ded. Waived | Ded. Waived |
| Preventive | 100% | 100% |
| Basic | 80% | 80% |
| Major | 50% | 50% |
| Endo & Periodontics | 80% | 80% |
| Restorative | See EOC | See EOC |
| Waiting Period Basic | None | None |
| Waiting Period Major | None | None |
| Orthodontia Adult | Not Available | Not Available |
| Orthodontia Children (maximum age 18) | Not Available | Not Available |
| Waiting Period Ortho | None | None |
| **Dental Rewards** | | |
| Carry Over Amount | Not Available | Not Available |
| PPO Bonus | Not Available | Not Available |
| Benefit Threshold | Not Available | Not Available |
| Maximum Carry Over Amount | Not Available | Not Available |

The following premiums illustrate the cost to you ***after*** your employer has made their contribution. All family members must enroll with the same Participating Plan.

Your Employer has agreed to contribute:
Fixed Amount for Employee and Remainder for Dependents
$31.00 for Employee Rate
None for Dependent

| Carrier - Plan | Plan Type | These are your costs per pay period based on (12) paychecks per year | | | |
|---|---|---|---|---|---|
| **DeltaCare® USA** | | **Employee Only** | **Additional Cost for Spouse** | **Additional Cost for Child(ren)** | **Additional Cost for Family** |
| Silver | HMO | $ 0.00 | $ 3.62 | $ 3.86 | $ 19.22 |
| Gold | HMO | $ 0.00 | $ 7.75 | $ 8.03 | $ 25.25 |
| **Delta Dental FFS** | | **Employee Only** | **Additional Cost for Spouse** | **Additional Cost for Child(ren)** | **Additional Cost for Family** |
| Gold | PPO | $ 23.51 | $ 62.06 | $ 65.17 | $ 120.26 |
| Platinum | PPO | $ 39.57 | $ 79.58 | $ 79.68 | $ 150.01 |

We assume no liability for rate or benefit discrepancies.

| **Employee Enrollment Worksheet - Voluntary Vision** | ENVIRONMENTAL BUILDING STRATEG<br>Quote #: **000129197.007**<br>Employer Zip Code: 94111 | |
|---|---|---|

| VSP | Gold | Platinum |
|---|---|---|
| | **In-Network** | **In-Network** |
| Eye Examination | $10 Copay | $10 Copay |
| Frames | $150 Allowance | $150 Allowance |
| Standard Lenses | | |
| Single vision | $25 Copay | $25 Copay |
| Lined Bifocal | $25 Copay | $25 Copay |
| Lined Trifocal | $25 Copay | $25 Copay |
| Contact Lenses | $150 Allowance | $150 Allowance |
| Frequency in Months | | |
| Exam / Lenses / Frames | 12/12/24 | 12/12/12 |
| | **Out-of-Network** | **Out-of-Network** |
| Eye Examination | Up to $45 | Up to $45 |
| Frames | Up to $70 | Up to $70 |
| Standard Lenses | | |
| Single vision | Up to $30 | Up to $30 |
| Lined Bifocal | Up to $50 | Up to $50 |
| Lined Trifocal | Up to $65 | Up to $65 |
| Contact Lenses | Up to $105 | Up to $105 |
| Frequency in Months | | |
| Exam / Lenses / Frames | 12/12/24 | 12/12/12 |

The optional benefits listed below are being offered to you on a voluntary basis. Your employer is not required to make any premium contribution. If you choose to enroll, the premiums displayed will be your actual cost.

| Carrier - Plans | These are your costs per pay period based on (12) paychecks per year | | |
|---|---|---|---|
| **VSP** | **Employee Only** | **Additional Cost for 1 Dependent** | **Additional Cost for 2 Or More Dependents** |
| Gold | $ 8.80 | $ 8.51 | $ 19.09 |
| Platinum | $ 10.73 | $ 10.43 | $ 23.33 |