

Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 10/1/17

Bronze



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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 SBC (Summary of Benefits and Coverage), EOC (Evidence of Coverage) or COI (Certificate of Insurance), the EOC or COI applies.



Bronze HSP

Groups Beginning 10/1/17

Services	HSP A
Participating Health Plans	Health Net
Network Name	PureCare
Metal Tier	Bronze
Calendar Year Deductible*	\$5,000 / \$10,000 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$7,150 / \$14,300
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	\$45 Copay ¹
Specialist Visit (SPC)	\$60 Copay ¹
Laboratory	50%
X-Ray	50%
MRI, CT and PET (office setting)	50%
Hospital Services – In-Patient	50%
In-Patient Physician Fees	50%
Emergency Room (copay waived if admitted)	50%
Urgent Care	\$60 Copay
Hospital Services – Out-Patient	
Surgical Facility	50%
Ambulatory Surgery Center	50%
Hospital Pre-Authorization	Required
2nd Surgical Opinion	\$60 Copay
Ambulance Services (per trip)	50%
Rx Benefits	
Generic	\$15 Copay (ded waived)
Formulary Brand	\$500 / \$1,000 Ded – \$45 Copay
Non-Formulary Brand	\$500 / \$1,000 Ded – 50% (up to \$500 per prescription ⁶)
Specialty	\$500 / \$1,000 Ded – 50% (up to \$500 per prescription ⁶)
Oral Contraceptives	100%
Diabetes – Self-Injectable	\$500 / \$1,000 Ded – 50%
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ⁴
Chronic Disease Management	\$60 Copay
Chemotherapy	50%
Chiropractic (20 visits max per year)	Not Covered
Acupuncture	\$10 Copay
Physical, Occupational, Speech Therapy	\$45 Copay
Rehabilitative & Habilitative Services and Devices	\$45 Copay

Services	HSP A
Participating Health Plans	Health Net
Network Name	PureCare
Metal Tier	Bronze
Home Health Care (Max 100 visits per year)	50%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50% (no limit)
Hospice	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%
Mental Health	
In-Patient	50%
Out-Patient (office visit)	\$45 Copay
Drug/Substance Abuse	
In-Patient (Detox Only)	50%
Infertility	
Infertility Evaluation and Treatment	50% ²
Infertility Drugs	50% ²
In Vitro Fertilization (IVF)	Not Covered
Gamete Intrafallopian Transfer (GIFT)	50% ²
Zygote Intrafallopian Transfer (ZIFT)	Not Covered
Pediatric Vision	
Carrier	EyeMed ³
Network	EyeMed
Exam	100%
Contact Lenses	100%
Frames	1 pair per calendar year
Maximum Allowance per year	None
Pediatric Dental	
Carrier	Dental Benefit Providers ^{3,5}
Network	Dental Benefit Providers
Deductible	None
Out-of-Pocket Maximum	None
Office Visit	100%
Diagnostic & Preventative (D&P)	100%
Basic Services	Copay varies by service
Major Services (no waiting period)	Copay varies by service
Orthodontics (medically necessary)	Copay varies by service

* All services are subject to the deductible unless otherwise stated.

1. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
2. Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.
3. Pediatric dental and vision are included on all plans.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
6. Maximum member responsibility.



Bronze HMO

Groups Beginning 10/1/17

Services	HMO B	HMO C [†]	HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente		Sharp
Network Name	Full	Full		Premier
Metal Tier	Bronze	Bronze		Bronze
Calendar Year Deductible*	\$5,500 / \$11,000 ¹⁰ (applies to Max OOP)	\$5,000 / \$10,000 (combined Med/ Rx ded)(applies to Max OOP)		\$3,200 / \$6,400 ⁴ (combined Med/ Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,800 / \$13,600 ¹¹	\$6,550 / \$13,100		\$7,150 / \$14,300 ⁴
Lifetime Maximum	Unlimited	Unlimited		Unlimited
Dr. Office Visits (PCP)	\$70 Copay ¹²	65%		\$60 Copay
Specialist Visit (SPC)	\$70 Copay ¹²	65%		\$120 Copay
Laboratory	60%	65%		\$60 Copay
X-Ray	60%	65%		\$120 Copay
MRI, CT and PET (office setting)	60% per procedure	65% per procedure		\$400 Copay per procedure
Hospital Services – In-Patient	60%	65%		\$1,500 Copay per day – 3 days max
In-Patient Physician Fees	60%	65%		100%
Emergency Room (copay waived if admitted)	60%	65%		\$500 Copay
Urgent Care	\$70 Copay ¹²	65%		\$120 Copay
Hospital Services – Out-Patient				
Surgical Facility	60%	65%		60%
Ambulatory Surgery Center	60%	65%		60%
Hospital Pre-Authorization	Required	Required		Required
2nd Surgical Opinion	\$70 Copay	65%		\$120 Copay
Ambulance Services (per trip)	60%	65%		\$500 Copay
Rx Benefits				
Generic	\$1,000 Ded – \$20 Copay	65% (up to \$500 per prescription ⁹) (combined Med/Rx ded)		\$19 Copay (ded waived)
Formulary Brand	\$1,000 Ded – \$50 Copay	65% (up to \$500 per prescription ⁹) (combined Med/Rx ded)		\$60 Copay (combined Med/Rx ded)
Non-Formulary Brand	\$1,000 Ded – \$50 Copay (with physician approval)	65% (up to \$500 per prescription ⁹) (combined Med/Rx ded) (with physician approval)		\$120 Copay (combined Med/Rx ded)
Specialty	\$1,000 Ded – 80% (up to \$500 per prescription ⁹) (with physician approval)	65% (up to \$500 per prescription ⁹) (combined Med/Rx ded) (with physician approval)		Applicable Rx Copay (combined Med/Rx ded)
Oral Contraceptives	100%	100%		100% (if in formulary)
Diabetes – Self-Injectable	\$1,000 ded – \$50 Copay	65% (up to \$500 per prescription ⁹) (combined Med/Rx ded)		Applicable Rx Copay (combined Med/Rx ded)
Pre-Existing Conditions	Covered	Covered		Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness		Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ⁵	100% (ded waived) ⁵		100% (ded waived) ⁵
Chronic Disease Management	\$70 Copay	65%		\$120 Copay
Chemotherapy	100%	100%		Variable ⁸
Chiropractic (20 visits max per year)	Not Covered	Not Covered		Not Covered
Acupuncture	\$70 Copay	65%		\$60 Copay
Physical, Occupational, Speech Therapy	\$70 Copay	65%		\$60 Copay

Services	HMO B	HMO C†	HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente		Sharp
Network Name	Full	Full		Premier
Metal Tier	Bronze	Bronze		Bronze
Rehabilitative & Habilitative Services and Devices	\$70 Copay	65%		\$60 Copay
Home Health Care (Max 100 visits per year)	100% ¹	100% ¹		\$60 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	65%		\$200 Copay per day
Hospice	100%	100%		100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60% ⁶	65% ⁶		50%
Mental Health				
In-Patient	60%	65%		\$1,500 Copay per day – 3 days max
Out-Patient (office visit)	\$70 Copay ¹²	65%		\$60 Copay
Drug/Substance Abuse				
In-Patient (Detox Only)	60%	65%		\$1,500 Copay per day – 3 days max
Infertility				
Infertility Evaluation and Treatment	Not Covered	Not Covered		Not Covered
Infertility Drugs	Not Covered	Not Covered		Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered		Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered		Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered		Not Covered
Pediatric Vision				
Carrier	Kaiser Permanente	Kaiser Permanente		VSP
Network	Kaiser Permanente	Kaiser Permanente		VSP
Exam	100% (ded waived)	100% (ded waived)		100%
Contact Lenses	1 pair per calendar year	1 pair per calendar year		1 pair in lieu of eyeglasses
Frames	1 pair per calendar year (ded waived)	1 pair per calendar year (ded waived)		100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None		None
Pediatric Dental				
Carrier	Delta Dental	Delta Dental		Premier Access
Network	DeltaCare USA	DeltaCare USA		Access Dental DHMO
Deductible	None	None		None
Out-of-Pocket Maximum	\$350 / \$700	\$350 / \$700		\$1,000 / \$2,000 ⁷
Office Visit	100% (ded waived)	100% (ded waived)		\$20 Copay
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)		100%
Basic Services	\$95 Copay ²	\$95 Copay ²		\$95 Copay ²
Major Services (no waiting period)	\$365 Copay ³	\$365 Copay ³		\$365 Copay ³
Orthodontics (medically necessary)	\$350 Copay	\$350 Copay		\$1,000 Copay

† HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated.

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).

2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.

3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.

4. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.

5. See plan specific EOC information on preventive services.

6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.

7. The pediatric dental out-of-pocket maximum is \$1,000 for a family with one child and \$2,000 for a family with 2 or more children.

8. Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.

9. Maximum member responsibility.

10. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.

11. Under a family contract, an insured can satisfy their individual out-of-pocket maximum, however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.

12. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).



Bronze HMO

Groups Beginning 10/1/17

Services	HMO B† HSA Qualified	HMO D† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Full
Metal Tier	Bronze	Bronze	Bronze
Calendar Year Deductible*	\$4,750 / \$9,500 ¹⁰ (combined Med/Rx ded)(applies to Max OOP)	\$6,500 / \$13,000 ¹⁹ (combined Med/Rx ded) (applies to Max OOP)	\$6,300 / \$12,600 ¹ (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,550 / \$13,100 ¹⁰	\$6,550 / \$13,100 ^{19, 20}	\$6,800 / \$13,600 ²
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	\$60 Copay	\$75 Copay ^{8, 9}
Specialist Visit (SPC)	60%	\$120 Copay	\$105 Copay ⁸
Laboratory	60%	50%	\$40 Copay (ded waived)
X-Ray	60%	50%	100% ¹⁸
MRI, CT and PET (office setting)	60%	50%	100% ¹⁸
Hospital Services – In-Patient	60%	50%	100% ¹⁸
In-Patient Physician Fees	60%	50%	100% ¹⁸
Emergency Room (copay waived if admitted)	60%	50%	100% ¹⁸
Urgent Care	60%	\$120 Copay	\$75 Copay ⁹
Hospital Services – Out-Patient			
Surgical Facility	60%	50%	100% ¹⁸
Ambulatory Surgery Center	60%	50%	100% ¹⁸
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	\$120 Copay	\$105 Copay ⁸
Ambulance Services (per trip)	60%	50%	100% ¹⁹
Rx Benefits			
Generic	60% (up to \$500 per prescription ¹⁵) (combined Med/Rx ded)	\$30 Copay (combined Med/Rx ded)	\$500 / \$1,000 Ded – 100% ¹⁸ (up to \$500 per prescription ¹⁵) ³
Formulary Brand	60% (up to \$500 per prescription ¹⁵) (combined Med/Rx ded)	\$70 Copay (combined Med/Rx ded)	\$500 / \$1,000 Ded – 100% ¹⁸ (up to \$500 per prescription ¹⁵) ^{3, 4}
Non-Formulary Brand	60% (up to \$500 per prescription ¹⁵) (combined Med/Rx ded)	\$150 Copay (combined Med/Rx ded)	\$500 / \$1,000 Ded – 100% ¹⁸ (up to \$500 per prescription ¹⁵) ^{3, 4}
Specialty	60% (up to \$500 per prescription ¹⁵) (combined Med/Rx ded)	Applicable Rx Copay (combined Med/Rx ded)	\$500 / \$1,000 Ded – 100% ¹⁸ (up to \$500 per prescription ¹⁵) ^{3, 4}
Oral Contraceptives	100% (if in formulary)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	60% (up to \$500 per prescription ¹⁵) (combined Med/Rx ded)	Applicable Rx Copay (combined Med/Rx ded)	\$500 / \$1,000 Ded – Applicable Rx Copay ^{3, 4}
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ⁵	100% (ded waived) ⁵	100% (ded waived) ⁵
Chronic Disease Management	60%	\$120 Copay	Covered as any Illness
Chemotherapy	Variable ¹¹	Variable ²¹	100% ¹⁸
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	60%	\$60 Copay	\$75 Copay ⁸
Physical, Occupational, Speech Therapy	60%	\$60 Copay	\$75 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	60%	\$60 Copay	\$75 Copay (ded waived)
Home Health Care (Max 100 visits per year)	60%	\$60 Copay	100% ¹⁸

Services	HMO B [†] HSA Qualified	HMO D [†] HSA Qualified	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Full
Metal Tier	Bronze	Bronze	Bronze
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	50%	100% ¹⁸
Hospice	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	100% ¹⁸
Mental Health			
In-Patient	60%	50%	100% ^{16, 18}
Out-Patient (office visit)	60%	\$60 Copay	\$75 Copay ¹⁷
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	50%	100% ^{16, 18}
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	VSP	VSP
Network	VSP	VSP	Choice Network
Exam	100%	100%	100% (ded waived) ⁶
Contact Lenses	1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses; ded waived) ^{6, 7}
Frames	100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)	100% (ded waived) ^{6, 7}
Maximum Allowance per year	None	None	1 pair per year
Pediatric Dental			
Carrier	Premier Access	Premier Access	Delta Dental
Network	Access Dental DHMO	Access Dental DHMO	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	\$1,000 / \$2,000 ¹⁴	\$1,000 / \$2,000 ¹⁴	Combined with Medical
Office Visit	\$20 Copay	\$20 Copay	Copay varies by service
Diagnostic & Preventative (D&P)	100%	100%	100% (ded waived)
Basic Services	\$95 Copay ¹²	\$95 Copay ¹²	\$25 copay (ded waived)
Major Services (no waiting period)	\$365 Copay ¹³	\$365 Copay ¹³	Copay varies by service (ded waived)
Orthodontics (medically necessary)	\$1,000 Copay	\$1,000 Copay	\$1,000 Copay (ded waived)

† HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated.

1. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or \$2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.

2. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.

3. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.

4. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.

5. See plan specific EOC for information on preventive services.

6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.

7. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.

8. Deductible is waived for the first three non-preventive visits (combined for primary care, specialist, urgent care, acupuncture and outpatient mental health).

9. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.

10. In high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.

(Foot notes continued on page 16)



Bronze HMO

Groups Beginning 10/1/17

Services	HMO B [†] HSA Qualified	HMO B [†] HSA Qualified	HMO C
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	Alliance	Alliance
Metal Tier	Bronze	Bronze	Bronze
Calendar Year Deductible*	\$4,800 / \$9,600 ³ (combined Med/Rx ded) (applies to Max OOP)	\$6,500 / \$13,000 ² (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)	\$6,000 / \$12,000 ² (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,550 / \$13,100 ⁵	\$6,500 / \$13,000 ⁴	\$6,750 / \$13,500 ⁴
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60% ¹⁴	100%	70%
Specialist Visit (SPC)	60%	100%	70%
Laboratory	60%	100%	70%
X-Ray	60%	100%	70%
MRI, CT and PET (office setting)	60%	100%	70%
Hospital Services – In-Patient	60%	100%	70%
In-Patient Physician Fees	60%	100%	70%
Emergency Room (copay waived if admitted)	60%	100%	70%
Urgent Care	60%	100%	70%
Hospital Services – Out-Patient			
Surgical Facility	60%	100%	70%
Ambulatory Surgery Center	60%	100%	70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	100%	70%
Ambulance Services (per trip)	60%	100%	70%
Rx Benefits			
Generic	60% (up to \$500 per prescription ⁹) (combined Med/Rx ded) ¹⁰	100% (combined Med/Rx/ Pediatric dental ded)	\$25 Copay (ded waived)
Formulary Brand	60% (up to \$500 per prescription ⁹) (combined Med/Rx ded) ^{10, 11}	100% (combined Med/Rx/ Pediatric dental ded) ⁶	\$250 / \$500 Ded – \$50 Copay ⁶
Non-Formulary Brand	60% (up to \$500 per prescription ⁹) (combined Med/Rx ded) ^{10, 11}	100% (combined Med/Rx/ Pediatric dental ded) ⁶	\$250 / \$500 Ded – \$125 Copay ⁶
Specialty	60% (up to \$500 per prescription ⁹) (combined Med/Rx ded) ^{10, 11}	100% (combined Med/Rx/ Pediatric dental ded) ⁶	\$250 / \$500 Ded – 50% (up to \$500 per prescription ⁹) ⁶
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100%
Diabetes – Self-Injectable	60% (up to \$500 per prescription ⁹) (combined Med/Rx ded) ^{10, 11}	100% (combined Med/Rx/ Pediatric dental ded) ⁶	\$250 / \$500 Ded – Application Rx Copay ⁶
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ¹	100% (ded waived) ¹	100% (ded waived) ¹
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	60%	100%	70% ⁷
Chiropractic (20 visits max per year)	Not Covered	100%	70%
Acupuncture	60%	100%	70%
Physical, Occupational, Speech Therapy	60%	100%	70%
Rehabilitative & Habilitative Services and Devices	60%	100%	70%

Services	HMO B [†] HSA Qualified	HMO B [†] HSA Qualified	HMO C
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	Alliance	Alliance
Metal Tier	Bronze	Bronze	Bronze
Home Health Care (Max 100 visits per year)	60%	100%	70%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	60%	100%	70%
Mental Health			
In-Patient	60% ¹⁵	100%	70%
Out-Patient (office visit)	60% ¹⁶	100%	70%
Drug/Substance Abuse			
In-Patient (Detox Only)	60% ¹⁵	100%	70%
Infertility			
Infertility Evaluation and Treatment	Not Covered	50%	50%
Infertility Drugs	Not Covered	See Plan Specific EOC	See Plan Specific EOC
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	50% ⁸	50% ⁸
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	Choice Network	Spectera Eyecare Networks	Spectera Eyecare Networks
Exam	100% (ded waived) ¹²	100% (ded waived)	100% (ded waived)
Contact Lenses	100% (in lieu of eyeglasses; ded waived) ^{12, 13}	100%	70% (ded waived)
Frames	100% (ded waived) ^{12, 13}	100%	70% (ded waived)
Maximum Allowance per year	1 pair per year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	Delta Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	DeltaCare USA	CA DHMO	CA DHMO
Deductible	None	Combined Med/Rx/Pediatric dental ded	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	\$25 copay (ded waived)	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service (ded waived)	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	\$1,000 Copay (ded waived)	\$1,000 Copay	\$1,000 Copay

[†] HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated.

1. See plan specific EOC for information on preventive services.

2. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.

3. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or \$2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing

listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.

4. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.

5. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.

6. For Specialty drugs, please see plan specific EOC.

7. For instances where the contracted rate is less than your copayment, you will only pay the contracted rate.

8. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.

9. Maximum member responsibility.

(Foot notes continued on page 16)



Bronze HMO

Groups Beginning 10/1/17

Services	HMO B	HMO C†	HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	
Network Name	Full	Full	
Metal Tier	Bronze	Bronze	
Calendar Year Deductible*	\$6,300 / \$12,600 ^{1,7} (applies to Max OOP)	\$6,500 / \$13,000 ^{1,7} (combined Med/Rx ded)(applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$6,800 / \$13,600 ^{2,7}	\$6,500 / \$13,000 ^{2,7}	
Lifetime Maximum	Unlimited	Unlimited	
Dr. Office Visits (PCP)	\$75 Copay ⁹	100% ¹	
Specialist Visit (SPC)	\$105 Copay ⁹	100% ¹	
Laboratory	\$40 Copay (ded waived)	100% ¹	
X-Ray	100% ^{1,11}	100% ¹	
MRI, CT and PET (office setting)	100% ^{1,11}	100% ¹	
Hospital Services – In-Patient	100% ^{1,11}	100% ¹	
In-Patient Physician Fees	100% ^{1,11}	100% ¹	
Emergency Room (copay waived if admitted)	100% ^{1,11}	100% ¹	
Urgent Care	\$75 Copay ¹	100% ¹	
Hospital Services – Out-Patient			
Surgical Facility	100% ^{1,11}	100% ¹	
Ambulatory Surgery Center	100% ^{1,11}	100% ¹	
Hospital Pre-Authorization	Required	Required	
2nd Surgical Opinion	\$105 Copay ⁹	100% ¹	
Ambulance Services (per trip)	100% ^{1,11}	100% ¹	
Rx Benefits			
Generic	\$500 / \$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁸) ¹	100% (combined Med/Rx ded) ¹	
Formulary Brand	\$500 / \$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁸) ^{1,13}	100% (combined Med/Rx ded) ^{1,13}	
Non-Formulary Brand	\$500 / \$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁸) ^{1,13}	100% (combined Med/Rx ded) ^{1,13}	
Specialty	\$500 / \$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁸) ¹	100% (combined Med/Rx ded) ¹	
Oral Contraceptives	100% (ded waived)	100% (ded waived)	
Diabetes – Self-Injectable	\$500 / \$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁸) ¹	100% (combined Med/Rx ded) ¹	
Pre-Existing Conditions	Covered	Covered	
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) ^{3,6}	100% (ded waived) ^{3,6}	
Chronic Disease Management	Covered as any Illness	Covered as any Illness	
Chemotherapy	100% ^{1,11}	100% ¹	
Chiropractic (20 visits max per year)	\$15 Copay (ded waived) ¹²	Not Covered	
Acupuncture	\$75 Copay ¹	100% ¹	
Physical, Occupational, Speech Therapy	\$75 Copay (ded waived)	100% ¹	
Rehabilitative & Habilitative Services and Devices	\$75 Copay (ded waived)	100% ¹	
Home Health Care (Max 100 visits per year)	100% ^{1,11}	100% ¹	

Services	HMO B	HMO C†	HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	
Network Name	Full	Full	
Metal Tier	Bronze	Bronze	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100% ^{1, 11}	100% ¹	
Hospice	100% (ded waived)	100% ¹	
Durable Medical Equipment (Covered when medically necessary)	100% ^{1, 5, 11}	100% ¹	
Mental Health			
In-Patient	100% ^{1, 11}	100% ¹	
Out-Patient (office visit)	\$75 Copay ⁹	100% ¹	
Drug/Substance Abuse			
In-Patient (Detox Only)	100% ^{1, 11}	100% ¹	
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	
Infertility Drugs	Not Covered	Not Covered	
In Vitro Fertilization (IVF)	Not Covered	Not Covered	
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	
Pediatric Vision			
Carrier	MES Vision	MES Vision	
Network	Eyewear Only	Eyewear Only	
Exam	100% (ded waived)	100% (ded waived)	
Contact Lenses	100% (ded waived)	100% (ded waived)	
Frames	100% (ded waived)	100% (ded waived)	
Maximum Allowance per year	1 per calendar year ¹⁰	1 per calendar year ¹⁰	
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	
Network	DeltaCare USA	DeltaCare USA	
Deductible	None	None	
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	
Office Visit	100%	100%	
Diagnostic & Preventative (D&P)	100%	100%	
Basic Services	Copay varies by service	Copay varies by service	
Major Services (no waiting period)	Copay varies by service	Copay varies by service	
Orthodontics (medically necessary)	\$1,000 Copay	\$1,000 Copay	

† HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated.

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.

8. Maximum member responsibility.

9. Deductible waived for first three non-preventive care visits.

10. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.

11. Covered in full after out-of-pocket maximum is met.

12. Copayments do not contribute to out-of-pocket maximum

13. Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.



Bronze HMO

Groups Beginning 10/1/17

Services	HMO D [†]	HSA Qualified
Participating Health Plans	Western Health Advantage	
Network Name	Full	
Metal Tier	Bronze	
Calendar Year Deductible*	\$4,800 / \$9,600 ^{1,7} (combined Med/Rx ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$6,550 / \$13,100 ^{2,7}	
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	60% ^{1,4}	
Specialist Visit (SPC)	60% ^{1,4}	
Laboratory	60% ^{1,4}	
X-Ray	60% ^{1,4}	
MRI, CT and PET (office setting)	60% ^{1,4}	
Hospital Services – In-Patient	60% ^{1,4}	
In-Patient Physician Fees	60% ^{1,4}	
Emergency Room (copay waived if admitted)	60% ^{1,4}	
Urgent Care	60% ^{1,4}	
Hospital Services – Out-Patient		
Surgical Facility	60% ^{1,4}	
Ambulatory Surgery Center	60% ^{1,4}	
Hospital Pre-Authorization	Required	
2nd Surgical Opinion	60% ^{1,4}	
Ambulance Services (per trip)	60% ^{1,4}	
Rx Benefits		
Generic	60% (up to \$500 per 30 day supply ⁹) (combined Med/Rx ded) ^{1,4}	
Formulary Brand	60% (up to \$500 per 30 day supply ⁹) (combined Med/Rx ded) ^{1,4,10}	
Non-Formulary Brand	60% (up to \$500 per 30 day supply ⁹) (combined Med/Rx ded) ^{1,4,10}	
Specialty	60% (up to \$500 per 30 day supply ⁹) (combined Med/Rx ded) ^{1,4}	
Oral Contraceptives	100% (ded waived)	
Diabetes – Self-Injectable	60% (up to \$500 per 30 day supply ⁹) (combined Med/Rx ded) ^{1,4}	
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any illness	
Preventive/Wellness Services	100% (ded waived) ^{3,6}	
Chronic Disease Management	Covered as any illness	
Chemotherapy	60% ^{1,4}	
Chiropractic (20 visits max per year)	Not Covered	
Acupuncture	60% ^{1,4}	
Physical, Occupational, Speech Therapy	60% ^{1,4}	
Rehabilitative & Habilitative Services and Devices	60% ^{1,4}	

Services	HMO D [†] HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	Bronze
Home Health Care (Max 100 visits per year)	60% ^{1,4}
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% ^{1,4}
Hospice	100% ¹
Durable Medical Equipment (Covered when medically necessary)	60% ^{1,4,5}
Mental Health	
In-Patient	60% ^{1,4}
Out-Patient (office visit)	60% ^{1,4}
Drug/Substance Abuse	
In-Patient (Detox Only)	60% ^{1,4}
Infertility	
Infertility Evaluation and Treatment	Not Covered
Infertility Drugs	Not Covered
In Vitro Fertilization (IVF)	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered
Pediatric Vision	
Carrier	MES Vision
Network	Eyewear Only
Exam	100% (ded waived)
Contact Lenses	100% (ded waived)
Frames	100% (ded waived)
Maximum Allowance per year	1 per calendar year ⁸
Pediatric Dental	
Carrier	Delta Dental
Network	DeltaCare USA
Deductible	None
Out-of-Pocket Maximum	Combined with Medical
Office Visit	100%
Diagnostic & Preventative (D&P)	100% (ded waived)
Basic Services	Copay varies by service
Major Services (no waiting period)	Copay varies by service
Orthodontics (medically necessary)	\$1,000 Copay

[†] HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated.

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.
8. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
9. Maximum member responsibility.
10. Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.



Bronze EPO

Groups Beginning 10/1/17

Services	EPO A	EPO B HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group	Prudent Buyer – Small Group
Metal Tier	Bronze	Bronze
Calendar Year Deductible*	\$5,600 / \$11,200 ¹ (combined Med/ Pediatric dental ded) (applies to Max OOP)	\$5,500 / \$11,000 ¹ (combined Med/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$7,150 / \$14,300 ²	\$6,550 / \$13,100 ²
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$65 Copay (first 3 visits) ⁸ – 60%	80%
Specialist Visit (SPC)	\$65 Copay (first 3 visits) ⁸ – 60%	80%
Laboratory	60%	80%
X-Ray	60%	80%
MRI, CT and PET (office setting)	60% ¹⁴	80% ¹⁴
Hospital Services – In-Patient		
In-Patient Physician Fees	\$1,000 Copay per admit	80%
Emergency Room (copay waived if admitted)	60%	80%
Urgent Care	\$400 Copay – 60%	80%
Hospital Services – Out-Patient		
Surgical Facility	\$500 Copay per admit – 60%	80%
Ambulatory Surgery Center	\$500 Copay per admit – 60%	80%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	\$65 Copay (first 3 visits) ⁸ – 60%	80%
Ambulance Services (per trip)	60% ¹⁰	80% ¹⁰
Rx Benefits		
Generic	\$5 Copay / \$20 Copay (ded waived) ⁹	80% (up to \$250 per prescription ³) (combined Med/Rx/Pediatric dental ded) ⁹
Formulary Brand	\$500 / \$1,000 Ded – \$50 Copay ⁹	80% (up to \$250 per prescription ³) (combined Med/Rx/Pediatric dental ded) ⁹
Non-Formulary Brand	\$500 / \$1,000 Ded – \$90 Copay ⁹	80% (up to \$250 per prescription ³) (combined Med/Rx/Pediatric dental ded) ⁹
Specialty	\$500 / \$1,000 Ded – 70% (up to \$250 per prescription ³) (prior auth. required) ^{4,9}	80% (up to \$250 per prescription ³) (combined Med/Rx/Pediatric dental ded) (prior auth. required) ^{4,9}
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay ⁹	80% (up to \$250 per prescription ³) (combined Med/Rx/Pediatric dental ded) ⁹
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ⁶	100% (ded waived) ⁶
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	60%	80%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) ¹¹	50% (20 visits max per benefit period) ¹¹
Acupuncture	60%	80%
Physical, Occupational, Speech Therapy	60%	80%
Rehabilitative & Habilitative Services and Devices	60% ¹²	80% ¹²

Services	EPO A	EPO B † HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group	Prudent Buyer – Small Group
Metal Tier	Bronze	Bronze
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) ⁵	80% (Max 100 visits per benefit period) ⁵
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$1,000 Copay per admit ¹³	80% ¹³
Hospice	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%
Mental Health		
In-Patient	\$1,000 Copay per admit	80%
Out-Patient (office visit)	\$65 Copay (first 3 visits) ⁸ – 60%	80%
Drug/Substance Abuse		
In-Patient (Detox Only)	\$1,000 Copay per admit	80%
Infertility		
Infertility Evaluation and Treatment	\$65 Copay (first 3 visits) ⁸ – 60% ⁷	80% ⁷
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	Anthem Vision	Anthem Vision
Network	Blue View Vision	Blue View Vision
Exam	100% (ded waived)	100% (ded waived)
Contact Lenses	1 pair per calendar year	100% (in lieu of eyeglasses)
Frames	1 pair per calendar year (ded waived)	100% (ded waived)
Maximum Allowance per year	1 per calendar year	1 pair per calendar year
Pediatric Dental		
Carrier	Anthem Dental	Anthem Dental
Network	Prime	Prime
Deductible	Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Office Visit	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)
Basic Services	50%	50%
Major Services (no waiting period)	50%	50%
Orthodontics (medically necessary)	50%	50%

† HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated.

1. Family Deductible: For any given member, cost share applies either after he/she meets their individual deductible, or after the entire family deductible is met. The family deductible can be met by any combination of amounts from any member, but no one member is required to meet his/her individual deductible.

2. Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.

3. Maximum member responsibility.

4. Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.

5. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.

6. See plan specific EOC for information on preventive services.

7. Evaluation only.

8. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived

for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determine your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.

9. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.

10. Medical emergency only.

11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.

12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).

14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.



Bronze HMO

(Foot notes continued from page 7)

11. Copayment depends on type and location of service.
12. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
13. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
14. The pediatric dental out-of-pocket maximum is \$1,000 for a family with one child and \$2,000 for a family with 2 or more children
15. Maximum member responsibility.
16. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
17. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.
18. Covered in full after out-of-pocket maximum is met.
19. In high deductible health plans (HDHPs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.
20. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
21. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.

Bronze HMO

(Foot notes continued from page 9)

10. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
11. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
12. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
13. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
14. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
15. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
16. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.

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