Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 10/1/17

Platinum/Gold

CaliforniaChoice®
Your Health. Your Choice.®

Anthem BlueCross · Health Net® · KAISER PERMANENTE® · SHARP HEALTH PLAN · Sutter Health Plus Your Health Plan · UnitedHealthcare® · Western Health Advantage

CONTENTS

The benefits listed in this brochure were collected from all plans participating in the California*Choice*® *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.*

Platinum HMO

Groups Beginning 10/1/17

Services	HMO A	HMO A
Participating Health Plans	Anthem Blue Cross	Health Net
Network Name	Select HMO	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [9]	$2,000 / $4,000 [3]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$15 Copay	$20 Copay
Specialist Visit (SPC)	$30 Copay	$20 Copay
Laboratory	$15 Copay	$20 Copay
X-Ray	$15 Copay	$20 Copay
MRI, CT and PET (office setting)	$250 Copay per test [20]	$20 Copay per procedure
Hospital Services – In-Patient	$200 Copay per day – 4 days max per admit	$350 Copay
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	$150 Copay	$100 Copay
Urgent Care	$15 Copay	$20 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay $200 Copay	 $350 Copay $350 Copay
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$30 Copay	$20 Copay
Ambulance Services (per trip)	90% [15]	$50 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay / $15 Copay [16] $35 Copay [16] $70 Copay [16] 70% (up to $250 per prescription [14]) (prior auth. required) [12, 16]	 $5 Copay [6, 7] $20 Copay [6, 7] $50 Copay [6, 7] 70% (up to $250 per prescription [14]) (prior auth. required) [6, 7]
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [16]	Applicable Rx Copay [6, 7]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	$20 Copay
Chemotherapy	$30 Copay	100%
Chiropractic (20 visits max per year)	$15 Copay (20 visits max per benefit period) [17]	Not Covered
Acupuncture	$15 Copay	$20 Copay [1]
Physical, Occupational, Speech Therapy	$15 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$15 Copay [18]	$20 Copay
Home Health Care (Max 100 visits per year)	$15 Copay (Max 100 visits per benefit period) [11]	100%

Services	HMO A	HMO A
Participating Health Plans	Anthem Blue Cross	Health Net
Network Name	Select HMO	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100% [19]	$350 Copay (no limit)
Hospice	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	70%
Mental Health In-Patient Out-Patient (office visit)	 $200 Copay per day – 4 days max per admit $15 Copay	 $350 Copay [5] $20 Copay [5]
Drug/Substance Abuse In-Patient (Detox Only)	 $200 Copay per day – 4 days max per admit	 $350 Copay
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $15 Copay [13] Not Covered Not Covered Not Covered Not Covered	 50% [2] 50% [2] Not Covered 50% [2] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% 100% (in lieu of eyeglasses) 100% 1 per calendar year	 EyeMed [10] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime None Combined with Medical 100% 100% 50% 50% 50%	 Dental Benefit Providers [8, 10] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. Must be medically necessary.
2. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
3. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
4. See plan specific EOC for information on preventive services.
5. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
6. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. 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.
9. 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.
10. Pediatric dental and vision are included on all plans.
11. Limited to 100 4-hour visits per benefit period.
12. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
13. Evaluation only.
14. Maximum member responsibility.
15. Medical emergency only.
16. 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.
17. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
18. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
19. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
20. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Platinum HMO

Groups Beginning 10/1/17

Services	HMO A	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,500 / $7,000	$3,500 / $7,000 [4]	$3,000 / $6,000 [4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$10 Copay	$15 Copay	$15 Copay
Specialist Visit (SPC)	$10 Copay	$20 Copay	$30 Copay
Laboratory	$20 Copay	100%	100%
X-Ray	$40 Copay	100%	100%
MRI, CT and PET (office setting)	$150 Copay per procedure	$150 Copay per procedure	$100 Copay per procedure
Hospital Services – In-Patient	$300 Copay per day – 5 days max	$400 Copay	85%
In-Patient Physician Fees	100%	100%	85%
Emergency Room (copay waived if admitted)	$250 Copay	$150 Copay	85%
Urgent Care	$10 Copay	$20 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay $300 Copay	 80% 80%	 85% 85%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$10 Copay	$20 Copay	$30 Copay
Ambulance Services (per trip)	$200 Copay	$150 Copay	85%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay $15 Copay $15 Copay (with physician approval) 90% (up to $250 per prescription [9]) (with physician approval)	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay
Oral Contraceptives	100%	100% (if in formulary)	100% (if in formulary)
Diabetes – Self-Injectable	$15 Copay	Applicable Rx Copay	Applicable Rx Copay
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% [5]	100% [5]	100% [5]
Chronic Disease Management	$10 Copay	$20 Copay	$30 Copay
Chemotherapy	100%	Variable [8]	Variable [8]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay	$15 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$10 Copay	$15 Copay	$15 Copay
Rehabilitative & Habilitative Services and Devices	$10 Copay	$15 Copay	$15 Copay
Home Health Care (Max 100 visits per year)	100% [1]	$15 Copay	$15 Copay

Platinum HMO

Groups Beginning 10/1/17

Services	HMO A	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 5 days max	$200 Copay	85%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	90% [6]	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $300 Copay per day – 5 days max $10 Copay	 $400 Copay $15 Copay	 85% $15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $300 Copay per day – 5 days max	 $400 Copay	 85%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year 1 pair per calendar year None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [2] $365 Copay [3] $350 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000 [7] $20 Copay 100% $95 Copay [2] $365 Copay [3] $1,000 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000 [7] $20 Copay 100% $95 Copay [2] $365 Copay [3] $1,000 Copay

* 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 for 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. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
9. Maximum member responsibility.

Platinum HMO

Groups Beginning 10/1/17

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [12]	$4,000 / $8,000 [1]	$3,500 / $7,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$10 Copay	$15 Copay [7]	$25 Copay [7]
Specialist Visit (SPC)	$20 Copay	$40 Copay	$25 Copay
Laboratory	$20 Copay	$20 Copay	$25 Copay
X-Ray	$40 Copay	$40 Copay	$25 Copay
MRI, CT and PET (office setting)	$150 Copay per procedure	$150 Copay	$150 Copay
Hospital Services – In-Patient	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max	$250 Copay per day – 5 days max
In-Patient Physician Fees	100%	$40 Copay	100%
Emergency Room (copay waived if admitted)	$200 Copay	$150 Copay	$100 Copay
Urgent Care	$20 Copay	$15 Copay	$25 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 $250 Copay $250 Copay	 90% 90%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$20 Copay	$40 Copay	$25 Copay
Ambulance Services (per trip)	$200 Copay	$150 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay	 $5 Copay [2] $15 Copay [2, 3] $25 Copay [2, 3] 90% (up to $250 per prescription [8]) [2, 3]	 $5 Copay [2] $15 Copay [2, 3] $25 Copay [2, 3] 90% (up to $250 per prescription [8]) [2, 3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay [2, 3]	Applicable Rx Copay [2, 3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as an Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	$20 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [11]	90%	90%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay	$15 Copay	$25 Copay
Physical, Occupational, Speech Therapy	$10 Copay	$15 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$10 Copay	$15 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$10 Copay	$20 Copay	$25 Copay

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay	$150 Copay per day – 5 days max	90%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	90%	90%
Mental Health In-Patient Out-Patient (office visit)	 $350 Copay per day – 5 days max $10 Copay	 $250 Copay per day – 5 days max [9] $15 Copay [10]	 $250 Copay per day – 5 days max [9] $25 Copay [10]
Drug/Substance Abuse In-Patient (Detox Only)	 $350 Copay per day – 5 days max	 $250 Copay per day – 5 days max [9]	 $250 Copay per day – 5 days max [9]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% [5] 100% (in lieu of eyeglasses) [5, 6] 100% [5, 6] 1 pair per year	 VSP Choice Network 100% [5] 100% (in lieu of eyeglasses) [5, 6] 100% [5, 6] 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Premier Access Access Dental DHMO None $1,000/$2,000 [13] $20 Copay 100% $95 Copay [14] $365 Copay [15] $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% $25 Copay Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% $25 Copay Copay varies by service $1,000 Copay

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

1. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
2. 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.
3. 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.
4. See plan specific EOC for information on preventive services.
5. 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.
6. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
7. 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.
8. Maximum member responsibility.
9. 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.
10. 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.
11. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
12. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum
13. 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.
14. 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.
15. 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.

Platinum HMO

Groups Beginning 10/1/17

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Focus	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000 [2]	$3,000 / $6,000 [2]	$3,000 / $6,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$20 Copay
Specialist Visit (SPC)	$40 Copay	$40 Copay	$40 Copay
Laboratory	$15 Copay	$15 Copay	$15 Copay
X-Ray	$15 Copay	$15 Copay	$15 Copay
MRI, CT and PET (office setting)	$100 Copay per procedure	$100 Copay per procedure	$100 Copay per procedure
Hospital Services – In-Patient	70%	70%	70%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$200 Copay	$200 Copay	$200 Copay
Urgent Care	$50 Copay	$50 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 70% 70%	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$40 Copay	$40 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay $35 Copay [3] $50 Copay [3] 75% (up to $250 per prescription [6]) [3]	 $15 Copay $35 Copay [3] $50 Copay [3] 75% (up to $250 per prescription [6]) [3]	 $15 Copay $35 Copay [3] $50 Copay [3] 75% (up to $250 per prescription [6]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [3]	Applicable Rx Copay [3]	Applicable Rx Copay [3]
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% [1]	100% [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [4]	$150 Copay [4]	$150 Copay [4]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$20 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$20 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$20 Copay	$20 Copay

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Focus	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	70%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$50 Copay	$50 Copay	$50 Copay
Mental Health In-Patient Out-Patient (office visit)	 70% $40 Copay	 70% $40 Copay	 70% $40 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 70%	 70%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% See Plan Specific EOC Not Covered 50% [5] Not Covered	 50% See Plan Specific EOC Not Covered 50% [5] Not Covered	 50% See Plan Specific EOC Not Covered 50% [5] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. 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.
3. For Specialty drugs, please see plan specific EOC.
4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
6. Maximum member responsibility.

Platinum HMO

Groups Beginning 10/1/17

Services	HMO A	HMO B
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$4,000 / $8,000 [1]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$15 Copay
Specialist Visit (SPC)	$25 Copay	$40 Copay
Laboratory	100%	$20 Copay
X-Ray	100%	$40 Copay
MRI, CT and PET (office setting)	$100 Copay	$150 Copay
Hospital Services – In-Patient	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5
In-Patient Physician Fees	100%	$40 Copay
Emergency Room (copay waived if admitted)	$150 Copay	$150 Copay
Urgent Care	$50 Copay	$15 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 $250 Copay $250 Copay
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$25 Copay	$40 Copay
Ambulance Services (per trip)	100%	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $30 Copay [9] $50 Copay [9] 80% (up to $250 per 30 day supply [6]) [3]	 $5 Copay $15 Copay [9] $25 Copay [9] 90% (up to $250 per 30 day supply [6]) [3]
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	$30 Copay	$15 Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [2, 5]	100% [2, 5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	90%
Chiropractic (20 visits max per year)	$15 Copay [8]	$15 Copay [8]
Acupuncture	$15 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$15 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$15 Copay
Home Health Care (Max 100 visits per year)	100%	$20 Copay

Services	HMO A	HMO B
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$250 Copay per day – Days 1-5	$150 Copay per day – Days 1-5
Hospice	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80% [3, 4]	90% [3, 4]
Mental Health In-Patient Out-Patient (office visit)	 $250 Copay per day – Days 1-5 $25 Copay	 $250 Copay per day – Days 1-5 $15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $250 Copay per day – Days 1-5	 $250 Copay per day – Days 1-5
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% 100% 100% 1 per calendar year [7]	 MES Vision Eyewear Only 100% 100% 100% 1 per calendar year [7]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

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

1. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
2. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
3. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
4. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. Maximum member responsibility.
7. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
8. Copayments do not contribute to out-of-pocket maximum.
9. 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.

Gold HMO

Groups Beginning 10/1/17

Services	HMO A
Participating Health Plans	Anthem Blue Cross
Network Name	Select HMO
Metal Tier	**Gold**
Calendar Year Deductible *	None
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [4]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	$25 Copay
Specialist Visit (SPC)	$50 Copay
Laboratory	$25 Copay
X-Ray	$25 Copay
MRI, CT and PET (office setting)	$250 Copay per test [12]
Hospital Services – In-Patient	$500 Copay per day – 4 days max per admit
In-Patient Physician Fees	100%
Emergency Room (copay waived if admitted)	$250 Copay
Urgent Care	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $500 Copay
Hospital Pre-Authorization	Required
2nd Surgical Opinion	$50 Copay
Ambulance Services (per trip)	70% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay / $20 Copay [2] $40 Copay [2] $80 Copay [2] 70% (up to $250 per prescription [10]) (prior auth. required) [2, 8]
Oral Contraceptives	100%
Diabetes – Self-Injectable	Applicable Rx Copay [2]
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% [3]
Chronic Disease Management	Covered as any Illness
Chemotherapy	$50 Copay
Chiropractic (20 visits max per year)	$25 Copay (20 visits max per benefit period) [6]
Acupuncture	$25 Copay
Physical, Occupational, Speech Therapy	$25 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay [7]
Home Health Care (Max 100 visits per year)	$25 Copay (Max 100 visits per benefit period) [5]

Services	HMO A
Participating Health Plans	Anthem Blue Cross
Network Name	Select HMO
Metal Tier	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%[11]
Hospice	100%
Durable Medical Equipment (Covered when medically necessary)	50%
Mental Health In-Patient Out-Patient (office visit)	 $500 Copay per day – 4 days max per admit $25 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $500 Copay per day – 4 days max per admit
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $25 Copay[9] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% 100% (in lieu of eyeglasses) 100% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime None Combined with Medical 100% 100% 50% 50% 50%

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

1. Medical emergency only.
2. 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.
3. See plan specific EOC for information on preventive services.
4. 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.
5. Limited to 100 4-hour visits per benefit period.
6. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
9. Evaluation only.
10. Maximum member responsibility.
11. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
12. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold HMO & HSP

Groups Beginning 10/1/17

Services	HMO A	HMO B	HSP A
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	PureCare
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$500 / $1,000 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700	$7,000 / $14,000	$7,150 / $14,300
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$50 Copay	$3 Copay [10]
Specialist Visit (SPC)	$45 Copay	$65 Copay	$15 Copay [10]
Laboratory	$40 Copay	$40 Copay	$15 Copay
X-Ray	$50 Copay	$50 Copay	$15 Copay
MRI, CT and PET (office setting)	$250 Copay per procedure	$300 Copay per procedure	$300 Copay per procedure
Hospital Services – In-Patient	$650 Copay	$1,300 Copay	50%
In-Patient Physician Fees	100%	100%	50%
Emergency Room (copay waived if admitted)	$250 Copay	$300 Copay	50%
Urgent Care	$45 Copay	$65 Copay	$15 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 50% 50%	 50% 50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$45 Copay	$65 Copay	$15 Copay
Ambulance Services (per trip)	$250 Copay	$300 Copay	50%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay [5, 7] $50 Copay [5, 6, 7] $60 Copay [5, 6, 7] 60% (up to $250 per prescription [11]) (prior auth. required) [5, 6, 7]	 $10 Copay [5, 7] $50 Copay [5, 6, 7] $70 Copay [5, 6, 7] 50% (up to $250 per prescription [11]) (prior auth. required) [5, 6, 7]	 $5 Copay (overall ded waived) $30 Copay (overall ded waived) 50% (up to $250 per prescription [11]) (overall ded waived) 50% (up to $250 per prescription [11]) (overall ded waived)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [5, 6, 7]	Applicable Rx Copay [5, 6, 7]	50% (overall ded waived)
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% [3]	100% [3]	100% (ded waived) [3]
Chronic Disease Management	$45 Copay	$65 Copay	$15 Copay
Chemotherapy	100%	100%	50%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay [1]	$10 Copay [1]	$3 Copay
Physical, Occupational, Speech Therapy	$30 Copay	$50 Copay	$3 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay	$50 Copay	$3 Copay
Home Health Care (Max 100 visits per year)	$30 Copay	$50 Copay	50%

Services	HMO A	HMO B	HSP A
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	PureCare
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	50% (no limit)
Hospice	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $650 Copay [4] $30 Copay [4]	 $1,300 Copay [4] $50 Copay [4]	 50% $3 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $650 Copay	 $1,300 Copay	 50%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% [2] 50% [2] Not Covered 50% [2] Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 50% [2] 50% [2] Not Covered 50% [2] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. Must be medically necessary.
2. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
3. See plan specific EOC for information on preventive services.
4. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
5. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
6. The brand-name prescription drug deductible (per member, per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. 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.
9. Pediatric dental and vision are included on all plans.
10. 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.
11. Maximum member responsibility.

Gold HMO

Groups Beginning 10/1/17

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Performance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$500 / $1,000 [6] (applies to Max OOP)	None	None
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [7]	$6,000 / $12,000	$6,500 / $13,000 [4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay (ded waived)	$30 Copay	$20 Copay
Specialist Visit (SPC)	$30 Copay (ded waived)	$50 Copay	$50 Copay
Laboratory	$30 Copay (ded waived)	$40 Copay	$10 Copay
X-Ray	$30 Copay (ded waived)	$55 Copay	$10 Copay
MRI, CT and PET (office setting)	$150 Copay per procedure (ded waived)	$250 Copay per procedure	$175 Copay per procedure
Hospital Services – In-Patient	$600 Copay per day – 5 days max	$600 Copay per day – 5 days max	70%
In-Patient Physician Fees	100%	100%	70%
Emergency Room (copay waived if admitted)	$250 Copay	$300 Copay	70%
Urgent Care	$30 Copay (ded waived)	$30 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $600 Copay $600 Copay	 $600 Copay $600 Copay	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$25 Copay	$30 Copay	$50 Copay
Ambulance Services (per trip)	$250 Copay	$250 Copay	70%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) $50 Copay (overall ded waived) (with physician approval) 80% (up to $250 per prescription [11]) (overall ded waived) (with physician approval)	 $15 Copay $55 Copay $55 Copay (with physician approval) 80% (up to $250 per prescription [11]) (with physician approval)	 $19 Copay (ded waived) $150 / $300 Ded – $35 Copay $150 / $300 Ded – $70 Copay $150 / $300 Ded – Applicable Rx Copay
Oral Contraceptives	100%	100%	100% (if in formulary)
Diabetes – Self-Injectable	$50 Copay (overall ded waived)	$55 Copay	$150 / $300 Ded – Applicable Rx Copay
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% [5]	100% [5]
Chronic Disease Management	$25 Copay	$50 Copay	$50 Copay
Chemotherapy	100% (ded waived)	100%	Variable [10]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$30 Copay (ded waived)	$30 Copay	$20 Copay
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	$30 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived)	$30 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	100% (ded waived) [1]	100% [1]	$20 Copay

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Performance
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max	$300 Copay per day – 5 days max	70%
Hospice	100% (ded waived)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) [8]	80% [8]	50%
Mental Health In-Patient Out-Patient (office visit)	 $600 Copay per day – 5 days max $30 Copay (ded waived)	 $600 Copay per day – 5 days max $30 Copay	 70% $20 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $600 Copay per day – 5 days max	 $600 Copay per day – 5 days max	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) None	 Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year 1 pair per calendar year None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $40 Copay [2] $365 Copay [3] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [2] $365 Copay [3] $350 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000 [9] $20 Copay 100% $95 Copay [2] $365 Copay [3] $1,000 Copay

* 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 for information on preventive services.
6. 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.
7. 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.
8. 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.
9. 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.
10. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
11. Maximum member responsibility.

Gold HMO

Groups Beginning 10/1/17

Services	HMO B	HMO C	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Premier	Premier	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$500 / $1,000[17] (applies to Max OOP)	$1,500 / $3,000[7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700[3]	$6,850 / $13,700[17, 18]	$2,500 / $5,000[8]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$10 Copay (ded waived)	$30 Copay[13]
Specialist Visit (SPC)	$60 Copay	$20 Copay (ded waived)	$30 Copay
Laboratory	$30 Copay	$20 Copay	$30 Copay
X-Ray	$60 Copay	$20 Copay	$30 Copay
MRI, CT and PET (office setting)	$175 Copay per procedure	$250 Copay per procedure	$50 Copay
Hospital Services – In-Patient	$600 Copay per day – 5 days max	50%	80%
In-Patient Physician Fees	100%	50%	80%
Emergency Room (copay waived if admitted)	$200 Copay	50%	$150 Copay
Urgent Care	$60 Copay	$20 Copay (ded waived)	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 75% 75%	 50% 50%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay	$20 Copay (ded waived)	$30 Copay
Ambulance Services (per trip)	$200 Copay	50% (ded waived)	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $19 Copay (ded waived) $150 / $300 Ded – $35 Copay $150 / $300 Ded – $70 Copay $150 / $300 Ded – Applicable Rx Copay	 $10 Copay (overall ded waived) $40 Copay (overall ded waived) $70 Copay (overall ded waived) Applicable Rx Copay (overall ded waived)	 $5 Copay (overall ded waived)[9] $15 Copay (overall ded waived)[9, 10] $25 Copay (overall ded waived)[9, 10] 80% (up to $250 per prescription[14]) (overall ded waived)[9, 10]
Oral Contraceptives	100% (if in formulary)	100% (overall ded waived)	100% (overall ded waived)
Diabetes – Self-Injectable	$150 / $300 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)	Applicable Rx Copay (overall ded waived)[9, 10]
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%[4]	100% (ded waived)[4]	100% (ded waived)[4]
Chronic Disease Management	$60 Copay	$20 Copay (ded waived)	Covered as any Illness
Chemotherapy	Variable[6]	Variable[6]	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$25 Copay	$10 Copay (ded waived)	$30 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$10 Copay (ded waived)	$30 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$10 Copay (ded waived)	$30 Copay
Home Health Care (Max 100 visits per year)	$25 Copay	$10 Copay (ded waived)	80%

Services	HMO B	HMO C	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Premier	Premier	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay per day	50%	80%
Hospice	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	80%
Mental Health In-Patient Out-Patient (office visit)	 $600 Copay per day – 5 days max $25 Copay	 50% $10 Copay (ded waived)	 80% [15] $30 Copay [16]
Drug/Substance Abuse In-Patient (Detox Only)	 $600 Copay per day – 5 days max	 50%	 80% [15]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [11] 100% (in lieu of eyeglasses; ded waived) [11, 12] 100% (ded waived) [11, 12] 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Premier Access Access Dental DHMO None $1,000 / $2,000 [5] $20 Copay 100% $95 Copay [1] $365 Copay [2] $1,000 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000 [5] $20 Copay 100% $95 Copay [1] $365 Copay [2] $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) $25 Copay (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)

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

1. 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.
2. 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.
3. 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.
4. See plan specific EOC for information on preventive services.
5. 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.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. 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.
8. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
9. 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.
10. 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.
11. 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.
12. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.

(Foot notes continued on page 30)

Gold HMO

Groups Beginning 10/1/17

Services	HMO B	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [7]	$5,500 / $11,000 [2]	$5,500 / $11,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay [8]	$30 Copay	$30 Copay
Specialist Visit (SPC)	$55 Copay	$50 Copay	$50 Copay
Laboratory	$35 Copay	$25 Copay	$25 Copay
X-Ray	$55 Copay	$25 Copay	$25 Copay
MRI, CT and PET (office setting)	$275 Copay	$200 Copay per procedure	$200 Copay per procedure
Hospital Services – In-Patient	$600 Copay per day – 5 days max	70%	70%
In-Patient Physician Fees	$55 Copay	100%	100%
Emergency Room (copay waived if admitted)	$325 Copay	$300 Copay	$300 Copay
Urgent Care	$30 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $600 Copay $600 Copay	 70% 70%	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$250 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [9] $55 Copay [9, 10] $75 Copay [9, 10] 80% (up to $250 per prescription [6]) [9, 10]	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [6]) [3]	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [6]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [9, 10]	Applicable Rx Copay [3]	Applicable Rx Copay [3]
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% [1]	100% [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	80%	$150 Copay [4]	$150 Copay [4]
Chiropractic (20 visits max per year)	Not Covered	$15 Copay	$15 Copay
Acupuncture	$30 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$30 Copay	$30 Copay	$30 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay	$30 Copay	$30 Copay
Home Health Care (Max 100 visits per year)	$30 Copay	$30 Copay	$30 Copay

Services	HMO B	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max	70%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80%	$50 Copay	$50 Copay
Mental Health In-Patient Out-Patient (office visit)	 $600 Copay per day – 5 days max [13] $30 Copay [14]	 70% $50 Copay	 70% $50 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $600 Copay per day – 5 days max [13]	 70%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 50% See Plan Specific EOC Not Covered 50% [5] Not Covered	 50% See Plan Specific EOC Not Covered 50% [5] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% [11] 100% (in lieu of eyeglasses) [11, 12] 100% [11, 12] 1 pair per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% $25 Copay Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. 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.
3. For Specialty drugs, please see plan specific EOC.
4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
6. Maximum member responsibility.
7. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
8. 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.
9. 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.
10. 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.
11. 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.
12. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
13. 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.
14. 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.

Gold HMO

Groups Beginning 10/1/17

Services	HMO C	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$5,500 / $11,000 [6]	$6,750 / $13,500 [1]	$6,750 / $13,500 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$40 Copay	$30 Copay
Specialist Visit (SPC)	$50 Copay	$40 Copay	$55 Copay
Laboratory	$25 Copay	$40 Copay	$35 Copay
X-Ray	$25 Copay	$40 Copay	$55 Copay
MRI, CT and PET (office setting)	$200 Copay per procedure	$300 Copay	$275 Copay
Hospital Services – In-Patient	70%	$600 Copay per day	$600 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%	$55 Copay
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$325 Copay
Urgent Care	$75 Copay	$100 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 $300 Copay $300 Copay	 $600 Copay $600 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$40 Copay	$55 Copay
Ambulance Services (per trip)	$100 Copay	100%	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay $35 Copay [7] $70 Copay [7] 75% (up to $250 per prescription [10]) [7]	 $20 Copay $50 Copay [13] $75 Copay [13] 80% (up to $250 per 30 day supply [10]) [3]	 $15 Copay $55 Copay [13] $75 Copay [13] 80% (up to $250 per 30 day supply [10]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [7]	$40 Copay	$50 Copay
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% [5]	100% [2, 5]	100% [2, 5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [8]	100%	80%
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay [12]	$15 Copay [12]
Acupuncture	$10 Copay	$15 Copay	$30 Copay
Physical, Occupational, Speech Therapy	$30 Copay	$40 Copay	$30 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay	$40 Copay	$30 Copay
Home Health Care (Max 100 visits per year)	$30 Copay	100%	$30 Copay

Services	HMO C	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	$600 Copay per day	$300 Copay per day – Days 1-5
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$50 Copay	80% [3, 4]	80% [3, 4]
Mental Health In-Patient Out-Patient (office visit)	 70% $50 Copay	 $600 Copay per day $40 Copay	 $600 Copay per day – Days 1-5 $30 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 70%	 $600 Copay per day	 $600 Copay per day – Days 1-5
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% See Plan Specific EOC Not Covered 50% [9] Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year	 MES Vision Eyewear Only 100% 100% 100% 1 per calendar year [11]	 MES Vision Eyewear Only 100% 100% 100% 1 per calendar year [11]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

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

1. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
2. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
3. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
4. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. 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.
7. For Specialty drugs, please see plan specific EOC.
8. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
9. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
10. Maximum member responsibility.
11. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
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.

Gold HMO

Groups Beginning 10/1/17

Services	HMO C	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Gold**	**Gold**
Calendar Year Deductible*	$1,000 / $2,000 [1,7] (applies to Max OOP)	$2,000 / $2,600 / $4,000 [1, 11] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [2, 7]	$4,000 / $8,000 [2]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay (ded waived)	100% [1]
Specialist Visit (SPC)	$40 Copay (ded waived)	100% [1]
Laboratory	100% (ded waived)	100% [1]
X-Ray	100% (ded waived)	100% [1]
MRI, CT and PET (office setting)	$250 Copay (ded waived)	100% [1]
Hospital Services – In-Patient	$500 Copay per day [1] – Days 1-5	100% [1]
In-Patient Physician Fees	100% (ded waived)	100% [1]
Emergency Room (copay waived if admitted)	$275 Copay [1]	100% [1]
Urgent Care	$50 Copay (ded waived)	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay [1] $500 Copay [1]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$40 Copay (ded waived)	100% [1]
Ambulance Services (per trip)	100% (ded waived)	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay (ded waived) $250 / $500 Ded – $50 Copay [1, 12] $250 / $500 Ded – $75 Copay [1, 12] $250 / $500 Ded – 80% (up to $250 per 30 day supply [9]) [1, 10]	 100% [1] (combined Med/Rx ded) $50 Copay (combined Med/Rx ded) [1, 12] $75 Copay (combined Med/Rx ded) [1, 12] 80% (up to $250 per 30 day supply [9]) (combined Med/Rx ded) [1, 10]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$250 / $500 Ded – $30 Copay [1]	100% [1] (combined Med/Rx ded)
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3,5]	100% (ded waived) [3,5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	100% (ded waived)	100% [1]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [8]	100% [1]
Acupuncture	$15 Copay (ded waived)	100% [1]
Physical, Occupational, Speech Therapy	$40 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$40 Copay (ded waived)	100% [1]
Home Health Care (Max 100 visits per year)	100% (ded waived)	100% [1]

Services	HMO C	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$500 Copay per day [1] – Days 1-5	100% [1]
Hospice	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) [4, 10]	100% [1,4]
Mental Health In-Patient Out-Patient (office visit)	 $500 Copay per day [1] – Days 1-5 $40 Copay (ded waived)	 100% [1] 100% [1]
Drug/Substance Abuse In-Patient (Detox Only)	 $500 Copay per day [1] – Days 1-5	 100% [1]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [6]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [6]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $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. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. Limited to one pair of glasses with standard lenses or one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.
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. Copayments do not contribute to out-of-pocket maximum.
9. Maximum member responsibility.
10. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
11. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
12. 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.

Gold PPO

Groups Beginning 10/1/17

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [10]	In-Network	Out-of-Network [10]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $2,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$750 / $2,250 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,500 / $3,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000 [1]	$12,000 / $24,000 [1]	$4,500 / $9,000 [1]	$9,000 / $18,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$25 Copay (first 3 visits) [9] – 80%	50%	$25 Copay (ded waived)	50%
Specialist Visit (SPC)	$25 Copay (first 3 visits) [9] – 80%	50%	$50 Copay (ded waived)	50%
Laboratory	80%	50%	80%	50%
X-Ray	80%	50%	80%	50%
MRI, CT and PET (office setting)	80% [15]	50% (up to $800 per test) [5, 15]	80% [15]	50% (up to $800 per test) [5, 15]
Hospital Services – In-Patient	Tier 1: 80% Tier 2: $500 Copay per admit – 80%	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%		$250 Copay – 80%	
Urgent Care	80%	50%	$50 Copay (ded waived)	50%
Hospital Services – Out-Patient				
Surgical Facility	Tier 1: 80% Tier 2: $250 Copay per admit – 80%	50% (up to $380 per admit) [5]	80%	50% (up to $380 per admit) [5]
Ambulatory Surgery Center	Tier 1: 80% Tier 2: $250 Copay per admit – 80%	50% (up to $380 per admit) [5]	80%	50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Required		Required	
2nd Surgical Opinion	$25 Copay (first 3 visits) [9] – 80%	50%	$50 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [14]		80% [14]	
Rx Benefits				
Generic	$5 Copay / $20 Copay (overall ded waived) [2]	Not Covered	$5 Copay / $20 Copay (ded waived) [2]	Not Covered
Formulary Brand	$40 Copay (overall ded waived) [2]	Not Covered	$250 / $500 Ded – $40 Copay [2]	Not Covered
Non-Formulary Brand	$80 Copay (overall ded waived) [2]	Not Covered	$250 / $500 Ded – $80 Copay [2]	Not Covered
Specialty	70% (up to $250 per prescription [8]) (overall ded waived) (prior auth.required) [2, 6]	Not Covered	$250 / $500 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) [2]	Not Covered	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	80%	50%	80%	50%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	Not Covered	50% (ded waived) (20 visits max per benefit period) [11]	Not Covered

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [10]	In-Network	Out-of-Network [10]
Acupuncture	80%	Not Covered	$25 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	80%	50%	80%	50%
Rehabilitative & Habilitative Services and Devices	80% [12]	50% [12]	80% [12]	50% [12]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 80% [13] Tier 2: $500 Copay per admit – 80% [13]	50% (up to $150 per day) [5, 13]	80% [13]	50% (up to $150 per day) [5, 13]
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 Tier 1: 80% Tier 2: $500 Copay per admit – 80% $25 Copay (first 3 visits) [9] – 80%	 50% (up to $650 per day) [5] 50%	 80% 25 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 Tier 1: 80% Tier 2: $500 Copay per admit – 80%	 50% (up to $650 per day) [5]	 80%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $25 Copay (first 3 visits) [9] – 80% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $25 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%

(Foot notes continued on page 30)

Gold PPO

Groups Beginning 10/1/17

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [10]	In-Network	Out-of-Network [10]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $2,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,200 / $2,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,400 / $4,800 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$8,000 / $16,000 [1]	$3,500 / $7,000 [1]	$7,000 / $14,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$25 Copay (first 3 visits) [9] – 80%	50%	$20 Copay (ded waived)	50%
Specialist Visit (SPC)	$25 Copay (first 3 visits) [9] – 80%	50%	$40 Copay (ded waived)	50%
Laboratory	80%	50%	80%	50%
X-Ray	80%	50%	80%	50%
MRI, CT and PET (office setting)	80% [15]	50% (up to $800 per test) [5, 15]	80% [15]	50% (up to $800 per test) [5, 15]
Hospital Services – In-Patient	$500 Copay per admit	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%		$250 Copay – 80%	
Urgent Care	80%	50%	$50 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit – 80% $250 Copay per admit – 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 80% 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Required		Required	
2nd Surgical Opinion	$25 Copay (first 3 visits) [9] – 80%	50%	$40 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [14]		80% [14]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay / $20 Copay (overall ded waived) [2] $40 Copay (overall ded waived) [2] $80 Copay (overall ded waived) [2] 70% (up to $250 per prescription [8]) (overall ded waived) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 $5 Copay / $20 Copay (ded waived) [2] $250 / $500 Ded – $40 Copay [2] $250 / $500 Ded – $80 Copay [2] $250 / $500 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) [2]	Not Covered	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	80%	50%	80%	50%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	Not Covered	50% (ded waived) (20 visits max per benefit period) [11]	Not Covered
Acupuncture	80%	Not Covered	$20 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	80%	50%	80%	50%

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [10]	In-Network	Out-of-Network [10]
Rehabilitative & Habilitative Services and Devices	80% [12]	50% [12]	80% [12]	50% [12]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$500 Copay per admit [13]	50% (up to $150 per day) [5, 13]	80% [13]	50% (up to $150 per day) [5, 13]
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $500 Copay per admit $25 Copay (first 3 visits) [9] – 80%	 50% (up to $650 per day) [5] 50%	 80% $20 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 $500 Copay per admit	 50% (up to $650 per day) [5]	 80%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $25 Copay (first 3 visits) [9] – 80% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $20 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic &Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%

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Additional Footnotes

Gold HMO

(Foot notes continued from page 19)

13. 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.
14. Maximum member responsibility.
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.
17. In a family plan, 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.
18. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum

Gold PPO

(Foot notes continued from page 27)

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

1. 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.
2. 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.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. 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 determining 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.
10. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
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. Medical emergency only.
15. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold PPO

(Foot notes continued from page 29)

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

1. 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.
2. 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.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. 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 determining 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.
10. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
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. Medical emergency only.
15. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

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