Employer

Program Guide

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 7/1/18

CaliforniaChoice®

Your Health. Your Choice.®

TABLE OF CONTENTS

ABOUT US 3

PROGRAM OVERVIEW 4

THREE STEPS TO ENROLL 9

BENEFIT HIGHLIGHTS 10

- PLATINUM PLANS 10
- GOLD PLANS 13
- SILVER PLANS 18
- BRONZE PLANS 23

OPTIONAL BENEFITS AND BUSINESS SOLUTIONS SUITE 27

- DENTAL 28
- VISION 30
- CHIROPRACTIC AND ACUPUNCTURE 32
- LIFE AND AD&D 33
- HEARING PROGRAM 34
- PRESCRIPTION DISCOUNTS 34
- HR SUPPORT 35
- HSA RESOURCES 35
- PAYROLL SERVICES 36
- EMPLOYEE DISCOUNTS 36
- COBRA BILLING 37
- FLEXIBLE SPENDING ACCOUNTS 37
- PREMIUM ONLY PLANS 37
- ADDITIONAL FOOTNOTES 38

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.

When we started California*Choice*®
in 1996, the idea of offering small
businesses a program that provided their
employees access to multiple health plans
and benefits was truly revolutionary.

Now, with over twenty years of
innovation and experience, we're uniquely
qualified to meet *and* exceed your
needs by offering you the most *Choice* —
at a price you can afford — while making
the process effortless.

California*Choice*®
It's that **simple.**

Everything you and your employees want in a benefits program:

SEVEN HEALTH PLANS IN ONE

COST CONTROL

GREATER ACCESS TO DOCTORS, SPECIALISTS, AND HOSPITALS

DENTAL, VISION, CHIROPRACTIC, AND LIFE BENEFITS

BUSINESS SOLUTIONS SUITE

CONSOLIDATED BILLING

DECISION-MAKING TOOLS

Incredible value. It's that **simple**.

SEVEN HEALTH PLANS IN ONE

With California*Choice*®, **each employee** can choose **any one of seven health plans** that best meets his or her unique personal and family needs.

For example, one of your employees might choose a PPO from Anthem Blue Cross because of a particular doctor or hospital in their network, while another employee who rarely visits the doctor might choose an HMO from Kaiser Permanente. A third employee might choose an HSA-compatible HMO from UnitedHealthcare because of cost and tax considerations. Whatever your employees' needs may be, it's their *Choice*!

Offering this level of *Choice* — without increasing your cost versus a single health plan solution — gives you a recruiting advantage and a powerful tool to retain your current employees.

COST CONTROL

Controlling costs is easy with **Defined Contribution** because you choose how much to contribute.

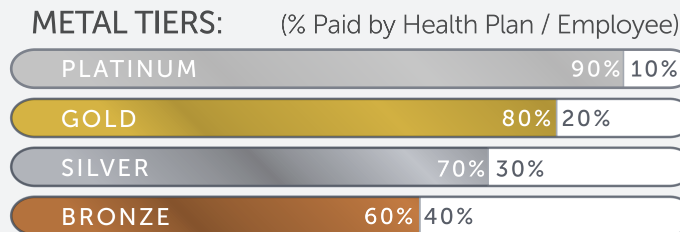
Contribute a **Fixed Percentage** (50% to 100%) of a specific plan and/or benefit, **or** you can choose to contribute a **Fixed Dollar Amount** for each employee. Your employees then apply your generous contribution to whichever health plan and benefits they prefer. If an employee selects a plan that costs more than your contribution, he or she simply pays the difference.

And when you renew with California*Choice*, you have the option to adjust your contribution up or down, giving you complete control over what you spend on employee benefits.

GREATER ACCESS TO DOCTORS, SPECIALISTS, AND HOSPITALS

Looking for a doctor? We offer a number of **full *and* limited networks** allowing you and your employees access to the doctors, specialists, and hospitals you want at the *best-possible price point*.

One tier or two? California*Choice*® offers health plans in all four metal tiers (Platinum, Gold, Silver, and Bronze). Each tier offers a different shared health care cost percentage, as shown below. We also offer **Tiered Choice**, which gives your employees **a choice of *two* tiers** (Platinum/Gold, Gold/Silver, Silver/Bronze) rather than just one. This can significantly increase the number of plans and doctors your employees can access.



Please keep in mind that some plans may pay a different percentage of health care costs than what is shown above for each tier; refer to each plan's summary of benefits for specific covered percentage details.

OPTIONAL BENEFITS

The following comprehensive **dental, vision, chiropractic**, and **life** benefits can be easily added to any California*Choice* plan:

OPTIONAL BENEFITS	
DENTAL	**SmileSaver℠ Dental HMO** offers office visits, oral exams, x-rays, and includes two free cleanings per year.
	Ameritas PPO benefits offer low deductibles that allow members to visit any dental provider they wish, in or out-of-network.
VISION	The **Voluntary Vision Program** offers comprehensive vision benefits and prescription eyewear.
CHIROPRACTIC	**Landmark Healthplan** offers chiropractic benefits including examinations, adjustments, and acupuncture.
LIFE AND AD&D	**Assurity Life Insurance Company** offers coverage amounts ranging from $10,000 to $75,000 and includes Accidental Death & Dismemberment and a living benefits provision.

BUSINESS SOLUTIONS SUITE

The Business Solutions Suite is included at **no extra charge** and offers you and your employees discount dental, vision, and hearing benefits, a free Premium Only Plan, human resources support, employee discounts, prescription discounts, and more!

Benefits vary by group size, as shown in the matrix below. Please see pages 27-37 for more info on Business Solutions Suite benefits.

BUSINESS SOLUTIONS SUITE	# of Employees in Group:	1-14	15-19	20+
DENTAL	**Dentegra® Smile Club** offers reduced fee dental care services and a network of more than 20,000 providers.	■	■	■
VISION	**EyeMed Vision One Eyecare Discount Program** provided by Ameritas offers discounts on frames, lenses, and eye examinations at many locations including Sears, LensCrafters, and Target.	■	■	■
HEARING	**EPIC Hearing** offers discounts up to 50% on hearing-related products, hearing tests, and more.	■	■	■
HR SUPPORT	**HRAnswerLink** offers you access to an online HR Support Center.	■	■	■
FSA	**Flexible Spending Accounts (FSA)** allow employees to set aside a portion of their salary on a pre-tax basis to use for eligible FSA medical expenses like copays and prescriptions.		■	■
COBRA	**Cal-COBRA Billing:** Includes participant invoicing and collection, premium remittance, payment tracking, and processing eligibility changes for non-payment scenarios.	■	■	
	Federal COBRA Billing: Same as above but as required for 20+ groups			■
EMPLOYEE DISCOUNTS	**Cal Perks Discount Program** offers discounts on movies, theme parks, hotels, and more.	■	■	■
POP*	**Premium Only Plans (POP)** allow employees to pay insurance premiums pre-tax. It also helps employers reduce their tax liability.	■	■	■
RX DISCOUNTS	The **California Rx Card® Program** offers discounts of up to 75% on prescriptions.	■	■	■
HSA RESOURCE CENTER	The **HSA Resource Center** helps employees learn more about HSAs and their advantages.	■	■	■

*Initial set-up is covered at no cost.

PROGRAM OVERVIEW

CONSOLIDATED BILLING

Whether you have one employee or 100, you'll get **a single, consolidated monthly bill** that lists all coverage levels, your contribution, and employee deductions. You can also pay your bill and manage your employee benefits online at **calchoice.com**.

Smart Decision Technology

Automated Choice Profiler (ACP) – a tool that gives members the power to compare health plans – not just based on your premium but also doctor availability, quality, affordability and how you use your plan.

Online Enrollment (OLE) – Go paperless and enroll your business online. It will help eliminate incomplete applications, reduce the number of pending items, and decrease processing time. Traditional paper-based enrollment is also still available – it's completely up to you. The choice is yours.

Online provider search tool – employees can find the health plans and benefits associated with their favorite doctor, look for a new doctor, or even search hospital and network affiliations.

Online Rx search tool – employees can search for their prescriptions and identify exactly which health care coverage they need.

Renewal Is Simple Too!

During your annual renewal period, employees can switch health plans and/or benefits without leaving CaliforniaChoice®. And you can change your contribution level depending on your company's changing financial picture – you decide what you want to spend.

THREE STEPS TO ENROLL

1 CHOOSE YOUR METAL TIER(S)

Give your employees access to the health plans and benefits available in a **single metal tier** or **two neighboring metal tiers** (for more information, see page 6).

OPTION 1:
SINGLE METAL TIER:

- PLATINUM
- GOLD
- SILVER
- BRONZE

OPTION 2:
TIERED CHOICE:

- PLATINUM & GOLD
- GOLD & SILVER
- SILVER & BRONZE

2 DEFINE YOUR MONTHLY CONTRIBUTION

Your broker will share plan premium information with you. Select your preferred plan and whether you want to pay a **Fixed Percentage** of costs (select from 50% to 100%) or a **Fixed Dollar Amount** toward that plan (for more information about Defined Contribution, please see page 5).

3 EMPLOYEES SELECT THEIR BENEFITS

After you select your metal tier(s) and define your contribution, each employee is provided with a personalized worksheet that spells out all options available, and the specific costs involved. Your employees also have access to other tools (see previous page) that make it easy to determine which plans best meet their needs.

On the following pages you'll find a brief summary of the benefits offered in each metal tier.

For more detailed benefit summaries, please contact your broker or visit ***calchoice.com****.*

BENEFIT HIGHLIGHTS
PlatinumHMO
Groups Beginning 7/1/18

Medical Benefits	HMO A ‡	HMO A ‡	HMO B‡
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	Salud HMO y Mas	WholeCare
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$10 Copay	$20 Copay	$20 Copay
Hospital Services - In-Patient	$200 Copay per day – 3 days max per admit	$350 Copay	$350 Copay
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay /$15 Copay [16] $35 Copay [16]	$5 Copay [3, 4] $20 Copay [3, 4]	$5 Copay [3, 4] $20 Copay [3, 4]
Out-of-Pocket Max Ind/Fam	$2,000 / $4,000 [6]	$2,000 / $4,000 [2]	$2,000 / $4,000
Out-Patient Surgical Facility	$150 Copay	$350 Copay	$350 Copay
Ambulance (per trip)	90% [15]	$50 Copay	$50 Copay

Medical Benefits	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Premier
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$10 Copay	$15 Copay	$15 Copay
Hospital Services - In-Patient	$500 Copay per admit	$250 Copay per day – 5 days max	$400 Copay
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$200 Copay	$150 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay $15 Copay	$5 Copay $15 Copay	$10 Copay $25 Copay
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000	$3,350 / $6,700	$3,500 / $7,000 [5]
Out-Patient Surgical Facility	$300 Copay per procedure	$125 Copay per procedure	80%
Ambulance (per trip)	$150 Copay	$150 Copay	$150 Copay

(Footnotes on page 12)

BENEFIT HIGHLIGHTS
PlatinumHMO
Groups Beginning 7/1/18

Medical Benefits	HMO B	HMO C	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$15 Copay	$10 Copay	$15 Copay [9]
Hospital Services - In-Patient	85%	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit
In-Patient Physician Fees	85%	100%	100%
Emergency Room (copay waived if admitted)	85%	$200 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay $25 Copay	$10 Copay $25 Copay	$5 Copay [10] $15 Copay [10, 11]
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000 [5]	$4,000 / $8,000 [14]	$3,350 / $6,700 [12]
Out-Patient Surgical Facility	85%	80%	$100 Copay
Ambulance (per trip)	85%	$200 Copay	$150 Copay

Medical Benefits	HMO B	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Focus
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$25 Copay [9]	$20 Copay	$20 Copay
Hospital Services - In-Patient	$250 Copay per day – 5 days max per admit	70%	70%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$100 Copay	70%	70%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay [10] $15 Copay [10, 11]	$15 Copay $35 Copay [7]	$15 Copay $35 Copay [7]
Out-of-Pocket Max Ind/Fam	$3,500 / $7,000 [12]	$2,500 / $5,000 [8]	$2,500 / $5,000 [8]
Out-Patient Surgical Facility	90%	70%	70%
Ambulance (per trip)	$100 Copay	$100 Copay	$100 Copay

(Footnotes on page 12)

BENEFIT HIGHLIGHTS

PlatinumHMO

Groups Beginning 7/1/18

Medical Benefits	HMO C	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Alliance	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$20 Copay	$25 Copay	$15 Copay
Hospital Services - In-Patient	70%	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	70%	$150 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay $35 Copay [7]	$10 Copay $30 Copay [13]	$5 Copay $15 Copay [13]
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [8]	$4,000 / $8,000 [1]	$3,350 / $6,700 [1]
Out-Patient Surgical Facility	70%	$100 Copay	$100 Copay
Ambulance (per trip)	$100 Copay	100%	$150 Copay

‡ This plan includes Infertility benefits; please see the California*Choice*® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

* 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. Certain services available in Mexico, have a separate OOPM, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both OOPMs.
3. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
4. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
5. 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.
6. 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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
7. For Specialty drugs, please see plan specific EOC.
8. 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.
9. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
10. 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 is 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 form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
11. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
12. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the 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.
14. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
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.

BENEFIT HIGHLIGHTS
GoldHMO & HSP
Groups Beginning 7/1/18

Medical Benefits	HMO A[‡]	HMO A[‡]
Participating Health Plans	Anthem Blue Cross	Health Net
Network Name	Select HMO	WholeCare
Metal Tier	**Gold**	**Gold**
Calendar Year Deductible*	None	None
Dr. Office Visits (PCP)	$25 Copay	$30 Copay
Hospital Services - In-Patient	$500 Copay per day – 3 days max per admit	$650 Copay
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay / $20 Copay [24] $40 Copay [24]	$10 Copay [2, 4] $50 Copay [2, 3, 4]
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000 [23]	$6,850 / $13,700
Out-Patient Surgical Facility	$500 Copay	60%
Ambulance (per trip)	70% [22]	$250 Copay

Medical Benefits	HMO B	HSP A[‡]
Participating Health Plans	Health Net	Health Net
Network Name	WholeCare	PureCare
Metal Tier	**Gold**	**Gold**
Calendar Year Deductible*	None	$500 / $1,000 (applies to Max OOP)
Dr. Office Visits (PCP)	$45 Copay	$5 Copay [15]
Hospital Services - In-Patient	$800 Copay	60%
In-Patient Physician Fees	100%	60%
Emergency Room (copay waived if admitted)	$300 Copay	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay [2, 4] $50 Copay [2, 3, 4]	$5 Copay (overall ded waived) $20 Copay (overall ded waived)
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000	$7,150 / $14,300
Out-Patient Surgical Facility	60%	60%
Ambulance (per trip)	$300 Copay	60%

(Footnotes on page 16)

CaliforniaChoice®
Your Health. Your Choice.®

BENEFIT HIGHLIGHTS

GoldHMO & HSP

Groups Beginning 7/1/18

Medical Benefits	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
Dr. Office Visits (PCP)	$30 Copay (ded waived)	$25 Copay	$20 Copay
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	$325 Copay	70%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay (overall ded waived) $50 Copay (overall ded waived)	$15 Copay $55 Copay	$19 Copay (ded waived) $150 / $300 Ded – $35 Copay
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000 [7]	$6,000 / $12,000	$6,500 / $13,000 [5]
Out-Patient Surgical Facility	$600 Copay per procedure	$340 Copay per procedure	70%
Ambulance (per trip)	$250 Copay	$250 Copay	70%

Medical Benefits	HMO B	HMO D	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Premier	Performance	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$1,500 / $3,000 [6] (applies to Max OOP)
Dr. Office Visits (PCP)	$25 Copay	$35 Copay	$30 Copay [11]
Hospital Services - In-Patient	$600 Copay per day – 5 days max	$1,500 Copay	80%
In-Patient Physician Fees	100%	100%	80%
Emergency Room (copay waived if admitted)	$200 Copay	$200 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$19 Copay (ded waived) $150 / $300 Ded – $35 Copay	$19 Copay $35 Copay	$5 Copay (overall ded waived) [12] $15 Copay (overall ded waived) [12, 13]
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700 [5]	$5,000 / $10,000 [20]	$2,500 / $5,000 [14]
Out-Patient Surgical Facility	75%	$600 Copay per procedure	80%
Ambulance (per trip)	$200 Copay	$200 Copay	$150 Copay

(Footnotes on page 16)

Medical Benefits	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
Dr. Office Visits (PCP)	$25 Copay [11]	$30 Copay	$30 Copay
Hospital Services - In-Patient	$600 Copay per day – 5 days max per admit	70%	70%
In-Patient Physician Fees	100%	70%	70%
Emergency Room (copay waived if admitted)	$325 Copay	70%	70%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay [12] $55 Copay [12, 13]	$15 Copay $35 Copay [8]	$15 Copay $35 Copay [8]
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000 [14]	$5,500 / $11,000 [9]	$5,500 / $11,000 [9]
Out-Patient Surgical Facility	$300 Copay	70%	70%
Ambulance (per trip)	$250 Copay	$100 Copay	$100 Copay

Medical Benefits	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
Dr. Office Visits (PCP)	$30 Copay	$40 Copay	$25 Copay
Hospital Services - In-Patient	70%	$600 Copay per day	$600 Copay per day – Days 1-5
In-Patient Physician Fees	70%	100%	100%
Emergency Room (copay waived if admitted)	70%	$300 Copay	$325 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay $35 Copay [8]	$20 Copay $50 Copay [19]	$15 Copay $55 Copay [19]
Out-of-Pocket Max Ind/Fam	$5,500 / $11,000 [9]	$6,750 / $13,500 [1]	$6,000 / $12,000 [1]
Out-Patient Surgical Facility	70%	$300 Copay	$300 Copay
Ambulance (per trip)	$100 Copay	100%	$250 Copay

(Footnotes on page 16)

BENEFIT HIGHLIGHTS

GoldHMO

Groups Beginning 7/1/18

HSA Qualified

Medical Benefits	HMO C	HMO D†
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Gold**	**Gold**
Calendar Year Deductible*	$1,000 / $2,000 [16, 17] (applies to Max OOP)	$2,000 / $2,700 / $4,000 [16, 18] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$40 Copay (ded waived)	100% [16]
Hospital Services - In-Patient	$500 Copay per day [16] – Days 1-5	100% [16]
In-Patient Physician Fees	100% (ded waived)	100% [16]
Emergency Room (copay waived if admitted)	$275 Copay [16]	100% [16]
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay (ded waived) $250 / $500 Ded – $50 Copay [16, 19]	100% (combined Med/Rx ded) [16] $30 Copay (combined Med/Rx ded) [16, 19]
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [1, 17]	$4,000 / $8,000 [1]
Out-Patient Surgical Facility	$500 Copay [16]	100% [16]
Ambulance (per trip)	100% (ded waived)	100% [16]

† A Health Savings (HSA)-qualified plan is a high-deductible health plan that offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified medical expenses with tax-advantaged dollars

‡ This plan includes Infertility benefits; please see the California*Choice*® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

* 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. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
3. 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.
4. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
5. 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.
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. For Specialty drugs, please see plan specific EOC.
9. 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.
10. 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 $2,700 for the 2018 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.
11. 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.
12. 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 is 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 form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
13. 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.
14. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
15. 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.
16. 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.

(Footnotes continued on page 38)

Medical Benefits	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 [6]	In-Network	Out-of-Network [6]
Calendar Year Deductible*	$500 / $1,500 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $2,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$750 / $2,250 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,500 / $3,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
Hospital Services - In-Patient	Tier 1: 80% Tier 2: $500 Copay per admit – 80%	50% (up to $650 per day) [4]	80%	50% (up to $650 per day) [4]
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 copay – 80%	$250 copay – 80%	$250 Copay – 80%	$250 Copay – 80%
Rx Benefits - Generic	$5 Copay / $20 Copay (overall ded waived) [1]	Not Covered	$5 Copay / $20 Copay (ded waived) [1]	Not Covered
Rx Benefits - Formulary Brand	$40 Copay (overall ded waived) [1]	Not Covered	$250 / $500 Ded – $40 Copay [1]	Not Covered
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000 [3]	$12,000 / $24,000 [3]	$4,500 / $9,000 [3]	$9,000 / $18,000 [3]
Out-Patient Surgical Facility	Tier 1: 80% Tier 2: $250 Copay per admit – 80%	50% (up to $380 per admit) [4]	80%	50% (up to $380 per admit) [4]
Ambulance (per trip)	80% [5]	80% [5]	80% [5]	80% [5]

Medical Benefits	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 [6]	In-Network	Out-of-Network [6]
Calendar Year Deductible*	$500 / $1,500 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $2,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,200 / $2,400 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,400 / $4,800 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$20 Copay (ded waived)	50%
Hospital Services - In-Patient	$500 Copay per admit	50% (up to $650 per day) [4]	80%	50% (up to $650 per day) [4]
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%	$250 Copay – 80%	$250 Copay – 80%	$250 Copay – 80%
Rx Benefits - Generic	$5 Copay / $20 Copay (overall ded waived) [1]	Not Covered	$5 Copay / $20 Copay (ded waived) [1]	Not Covered
Rx Benefits - Formulary Brand	$40 Copay (overall ded waived) [1]	Not Covered	$250 / $500 Ded – $40 Copay [1]	Not Covered
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [3]	$8,000 / $16,000 [3]	$3,500 / $7,000 [3]	$7,000 / $14,000 [3]
Out-Patient Surgical Facility	$250 Copay per admit – 80%	50% (up to $380 per admit) [4]	80%	50% (up to $380 per admit) [4]
Ambulance (per trip)	80% [5]	80% [5]	80% [5]	80% [5]

(Footnotes continued on page 38)

BENEFIT HIGHLIGHTS
SilverHMO & HSP
Groups Beginning 7/1/18

Medical Benefits	HMO A ‡	HMO A ‡	HMO B
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	WholeCare	CommunityCare
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,750 / $3,500 [25] (combined Med/ Pediatric dental ded)(applies to Max OOP)	None	None
Dr. Office Visits (PCP)	$55 Copay (ded waived)	$45 Copay	$45 Copay
Hospital Services - In-Patient	60%	50%	50%
In-Patient Physician Fees	100% (ded waived)	50%	50%
Emergency Room (copay waived if admitted)	$400 Copay – 60%	$300 Copay	$300 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay / $20 Copay (ded waived) [27] $250 / $500 Ded – $70 Copay [27]	$20 Copay (ded waived) [29, 30] $500 / $1,000 Ded – 50% (up to $250 per prescription [21]) [29, 30]	$20 Copay (ded waived) [29, 30] $500 / $1,000 Ded – 50% (up to $250 per prescription [21]) [29, 30]
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300 [26]	$7,200 / $14,400	$7,200 / $14,400
Out-Patient Surgical Facility	60%	50%	50%
Ambulance (per trip)	60% [24]	$300 Copay	$300 Copay

Medical Benefits	HSP A ‡	HMO B	HMO C
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,500 / $3,000 (applies to Max OOP)	$1,000 / $2,000 [5] (applies to Max OOP)	$2,000 / $4,000 [5] (applies to Max OOP)
Dr. Office Visits (PCP)	$30 Copay [18]	$50 Copay (ded waived)	$45 Copay (ded waived)
Hospital Services - In-Patient	50%	65%	80%
In-Patient Physician Fees	50%	65%	80%
Emergency Room (copay waived if admitted)	50%	65%	$350 Copay (ded waived)
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay (overall ded waived) $30 Copay (overall ded waived)	$25 Copay (ded waived) $250 Ded – $70 Copay	$125 Ded – $15 Copay $125 Ded – $55 Copay
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300	$7,000 / $14,000 [6]	$7,000 / $14,000 [6]
Out-Patient Surgical Facility	50%	65%	80% (ded waived)
Ambulance (per trip)	50%	65%	$250 Copay

(Footnotes on page 21)

BENEFIT HIGHLIGHTS
SilverHMO
Groups Beginning 7/1/18

Medical Benefits	HMO D† (HSA Qualified)	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $2,700 / $4,000 [28] (combined Med/Rx ded) (applies to Max OOP)	$2,100 / $4,200 [4] (applies to Max OOP)	$2,000 / $4,000 [4] (applies to Max OOP)
Dr. Office Visits (PCP)	80%	$40 Copay (ded waived)	$40 Copay (ded waived)
Hospital Services - In-Patient	80%	$750 Copay per day	60%
In-Patient Physician Fees	80%	100%	60%
Emergency Room (copay waived if admitted)	80%	$400 Copay	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	80% (combined Med/Rx ded) 80% (combined Med/Rx ded)	$20 Copay (ded waived) $200 / $400 Ded – $50 Copay	$20 Copay (ded waived) $200 / $400 Ded – $50 Copay
Out-of-Pocket Max Ind/Fam	$6,550 / $13,100 [6]	$6,000 / $12,000 [4]	$6,250 / $12,500 [4]
Out-Patient Surgical Facility	80%	50%	60%
Ambulance (per trip)	80%	$400 Copay (ded waived)	60% (ded waived)

Medical Benefits	HMO C	HMO B	HMO C† (HSA Qualified)
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [23] (applies to Max OOP)	$2,000 / $4,000 [12] (applies to Max OOP)	$2,000 / $2,700 / $4,000 [12, 17] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$45 Copay (ded waived) [13]	$35 Copay [13]
Hospital Services - In-Patient	50%	80%	80%
In-Patient Physician Fees	50%	80%	80%
Emergency Room (copay waived if admitted)	50%	$350 Copay (ded waived)	80%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$20 Copay (overall ded waived) $50 Copay (overall ded waived)	$125 / $250 Ded – $15 Copay [14] $125 / $250 Ded – $55 Copay [14, 15]	$10 Copay (combined Med/Rx ded) [14] $20 Copay (combined Med/Rx ded) [14, 15]
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700 [22, 23]	$7,000 / $14,000 [16]	$5,650 / $11,300 [16]
Out-Patient Surgical Facility	50%	80% (ded waived)	80%
Ambulance (per trip)	50% (ded waived)	$250 Copay (ded waived)	80%

(Footnotes on page 21)

BENEFIT HIGHLIGHTS

SilverHMO

Groups Beginning 7/1/18

Medical Benefits	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,250 / $4,500 [7] (applies to Max OOP)	$2,250 / $4,500 [7] (applies to Max OOP)	$2,000 / $4,000 [8] (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$50 Copay (ded waived)	70%
Hospital Services - In-Patient	60%	60%	70%
In-Patient Physician Fees	60% (ded waived)	60% (ded waived)	70%
Emergency Room (copay waived if admitted)	60%	60%	70%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$25 Copay (ded waived) $200 / $400 Ded – $50 Copay [9]	$25 Copay (ded waived) $200 / $400 Ded – $50 Copay [9]	$20 Copay (ded waived) $200 / $400 Ded – $50 Copay [9]
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [10]	$7,350 / $14,700 [10]	$6,750 / $13,500 [11]
Out-Patient Surgical Facility	60%	60%	70%
Ambulance (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	70%

Medical Benefits	HMO D	HMO A
Participating Health Plans	UnitedHealthcare	Western Health Advantage
Network Name	Focus	Full
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,250 / $4,500 [7] (applies to Max OOP)	$2,000 / $4,000 [1, 19] (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services - In-Patient	60%	80% [1, 3]
In-Patient Physician Fees	60% (ded waived)	100% (ded waived)
Emergency Room (copay waived if admitted)	60%	80% [1, 3]
Rx Benefits - Generic Rx Benefits - Formulary Brand	$25 Copay (ded waived) $200 / $400 Ded – $50 Copay [9]	$15 Copay (ded waived) $250 /$500 Ded – $55 Copay [1, 20]
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [10]	$7,000 / $14,000 [2, 21]
Out-Patient Surgical Facility	60%	$300 Copay [1]
Ambulance (per trip)	$100 Copay (ded waived)	100% (ded waived)

(Footnotes on page 21)

BENEFIT HIGHLIGHTS
SilverHMO
Groups Beginning 7/1/18

Medical Benefits	HMO B	HMO C† (HSA Qualified)
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [1, 19] (applies to Max OOP)	$2,000 / $2,700 / $4,000 [1, 17, 19] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$45 Copay (ded waived)	80% [1, 3]
Hospital Services - In-Patient	80% [1, 3]	80% [1, 3]
In-Patient Physician Fees	80% [1, 3]	80% [1, 3]
Emergency Room (copay waived if admitted)	$350 Copay (ded waived)	80% [1, 3]
Rx Benefits - Generic Rx Benefits - Formulary Brand	$125 / $250 Ded – $15 Copay $125 / $250 Ded – $55 Copay [1, 20]	80% (up to $250 per 30 day supply [21]) (combined Med/Rx ded) [1, 3] 80% (up to $250 per 30 day supply [21]) (combined Med/Rx ded) [1, 3, 20]
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000 [2, 19]	$6,550 / $13,100 [2, 19]
Out-Patient Surgical Facility	80% (ded waived) [3]	80% [1, 3]
Ambulance (per trip)	$250 Copay [1]	80% [1, 3]

† A Health Savings Account (HSA)-qualified health plan is a high-deductible health plan that often offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified medical expenses with tax-advantaged dollars.

‡ This plan includes Infertility benefits; please see the CaliforniaChoice® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

* 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. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
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. 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.
6. 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.
7. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
8. The Family Deductible is a non-embedded deductible. One or more eligible members of a family unit may satisfy the entire Family Deductible. No one in the family will be eligible for benefits until the Family Deductible has been satisfied.
9. For Specialty drugs, please see plan specific EOC.
10. 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.
11. When more than one person in a family is covered under the Health Plan, the Individual Out-of-Pocket Maximum does not apply. Copayments for Covered Services will continue to be required from every eligible member of the family until the Family Out-of-Pocket Maximum has been met. No further Copayments will be required for Covered Services (except infertility services) for the Calendar Year from any eligible family member once the Family Out-of-Pocket Maximum has been satisfied.
12. 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 $2,700 for the 2018 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.
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. 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 is 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 form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
15. 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.

(Footnotes continued on page 38 & 39)

CaliforniaChoice®
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BENEFIT HIGHLIGHTS

SilverPPO & EPO

Groups Beginning 7/1/18

Medical Benefits	PPO A ‡		PPO B ‡	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [8]	In-Network	Out-of-Network [8]
Calendar Year Deductible*	$1,250 / $2,500 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,500 / $5,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,500 / $3,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,000 / $6,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$40 Copay (ded waived)	50%	$40 Copay (ded waived)	50%
Hospital Services - In-Patient	Tier 1: 60% Tier 2: $500 Copay per admit – 60%	50% (up to $650 per day) [4]	$750 Copay per admit	50% (up to $650 per day) [4]
In-Patient Physician Fees	60%	50%	70%	50%
Emergency Room (copay waived if admitted)	$350 Copay – 60%	$350 Copay – 60%	$300 Copay – 70%	$300 Copay – 70%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay / $20 Copay (ded waived) [1] $250 / $500 Ded – $40 Copay [1]	Not Covered Not Covered	$5 Copay / $20 Copay (ded waived) [1] $250 / $500 Ded – $40 Copay [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [3]	$14,700 / $29,400 [3]	$7,350 / $14,700 [3]	$14,700 / $29,400 [3]
Out-Patient Surgical Facility	Tier 1: 60% Tier 2: $250 Copay per admit – 60%	50% (up to $380 per admit) [4]	$300 Copay per admit – 70%	50% (up to $380 per admit) [4]
Ambulance (per trip)	60% [5]	60% [5]	70% [5]	70% [5]

Medical Benefits	EPO A ‡	EPO B †, ‡ (HSA Qualified)
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group	Prudent Buyer – Small Group
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [2] (combined Med/ Pediatric dental ded) (applies to Max OOP)	$2,000 / $2,700 / $4,000 [7] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	80%
Hospital Services - In-Patient	$750 Copay per admit	80%
In-Patient Physician Fees	70%	80%
Emergency Room (copay waived if admitted)	$300 Copay – 70%	80%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay / $20 Copay (overall ded waived) [1] $40 Copay (overall ded waived) [1]	80% (up to $250 per prescription [6]) (combined Med/Rx/Pediatric dental ded) [1] 80% (up to $250 per prescription [6]) (combined Med/Rx/Pediatric dental ded) [1]
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300 [3]	$6,500 / $13,000 [3]
Out-Patient Surgical Facility	$300 Copay per admit – 70%	80%
Ambulance (per trip)	70% [5]	80% [5]

† A Health Savings Account (HSA)-qualified health plan is a high-deductible health plan that often offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified

‡ This plan includes Infertility benefits; please see the California*Choice*® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

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

1. 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.
2. 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; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
3. 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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
4. Amount listed is maximum paid by Anthem.

(Footnotes continued on page 39)

BENEFIT HIGHLIGHTS
BronzeHSP & HMO
Groups Beginning 7/1/18

Medical Benefits	HSP A[‡]	HMO A	HMO C[†] HSA Qualified
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,000 / $10,000 (applies to Max OOP)	$6,300 / $12,600 (applies to Max OOP)	$4,800 / $9,600 (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$45 Copay[8]	$75 Copay[13]	60%
Hospital Services - In-Patient	50%	100%[19]	60%
In-Patient Physician Fees	50%	100%[19]	60%
Emergency Room (copay waived if admitted)	50%	100%[19]	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay (ded waived) $500 / $1,000 Ded – $45 Copay	$500 Ded – 100% (up to $500 per prescription[18]) [19] $500 Ded – 100% (up to $500 per prescription[18]) [19]	60% (up to $500 per prescription[18]) (combined Med/Rx ded) 60% (up to $500 per prescription[18]) (combined Med/Rx ded)
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300	$7,000 / $14,000	$6,550 / $13,100
Out-Patient Surgical Facility	50%	100%[19]	60%
Ambulance (per trip)	50%	100%[19]	60%

Medical Benefits	HMO A	HMO B[†] HSA Qualified	HMO D[†] HSA Qualified
Participating Health Plans	Sharp	Sharp	Sharp
Network Name	Premier	Performance	Premier
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$3,200 / $6,400[4] (combined Med/Rx ded) (applies to Max OOP)	$4,750 / $9,500[10] (combined Med/Rx ded) (applies to Max OOP)	$3,500 / $7,000[23] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$60 Copay	60%	$60 Copay
Hospital Services - In-Patient	$1,500 Copay per day – 3 days max	60%	50%
In-Patient Physician Fees	100%	60%	50%
Emergency Room (copay waived if admitted)	$500 Copay	60%	50%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$19 Copay (ded waived) $60 Copay (combined Med/Rx ded)	60% (up to $500 per prescription[18]) (combined Med/Rx ded) 60% (up to $500 per prescription[18]) (combined Med/Rx ded)	$30 Copay (combined Med/Rx ded) $70 Copay (combined Med/Rx ded)
Out-of-Pocket Max Ind/Fam	$5,700 / $11,400[4]	$6,550 / $13,100[10]	$5,800 / $11,600[23, 24]
Out-Patient Surgical Facility	60%	60%	50%
Ambulance (per trip)	$500 Copay	60%	50%

(Footnotes on page 26)

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BENEFIT HIGHLIGHTS

BronzeHMO

Groups Beginning 7/1/18

Medical Benefits	HMO A	HMO B† (HSA Qualified)
Participating Health Plans	Sutter Health Plus	Sutter Health Plus
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 [11] (applies to Max OOP)	$4,800 / $9,600 [11] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$75 Copay [12, 13]	60% [12]
Hospital Services - In-Patient	100% [19]	60%
In-Patient Physician Fees	100% [19]	60%
Emergency Room (copay waived if admitted)	100% [19]	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$500 / $1,000 Ded – 100% [19] (up to $500 per prescription [18]) [14] $500 / $1,000 Ded – 100% [19] (up to $500 per prescription [18]) [14, 15]	60% (up to $500 per prescription [18]) (combined Med/Rx ded) [14] 60% (up to $500 per prescription [18]) (combined Med/Rx ded) [14, 15]
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000 [16]	$6,550 / $13,100 [16]
Out-Patient Surgical Facility	100% [19]	60%
Ambulance (per trip)	100% [19]	60%

Medical Benefits	HMO B† (HSA Qualified)	HMO C	HMO B
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Alliance	Alliance	Full
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,500 / $13,000 [5] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$6,250 / $12,500 [5] (applies to Max OOP)	$6,300 / $12,600 [1] (applies to Max OOP)
Dr. Office Visits (PCP)	100%	70%	$75 Copay [9]
Hospital Services - In-Patient	100%	70%	100% [1, 19]
In-Patient Physician Fees	100%	70%	100% [1, 19]
Emergency Room (copay waived if admitted)	100%	70%	100% [1, 19]
Rx Benefits - Generic Rx Benefits - Formulary Brand	100% (combined Med/Rx/ Pediatric dental ded) 100% (combined Med/Rx/ Pediatric dental ded) [6]	$25 Copay (ded wavied) $250 / $500 Ded - $100 Copay [6]	$500 / $1,000 Ded – 100% [19] (up to $500 per prescription [18]) [1] $500 / $1,000 Ded – 100% [19] (up to $500 per prescription [18]) [1, 22]
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [7]	$7,350 / $14,700 [7]	$7,000 / $14,000 [2]
Out-Patient Surgical Facility	100%	70%	100% [1, 19]
Ambulance (per trip)	100%	70%	100% [1, 19]

(Footnotes on page 26)

BENEFIT HIGHLIGHTS

BronzeHMO & EPO

Groups Beginning 7/1/18

Medical Benefits	HMO C † (HSA Qualified)	HMO D † (HSA Qualified)
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,500 / $13,000[1] (combined Med/ Rx ded)(applies to Max OOP)	$4,800 / $9,600[1,4] (combined Med/ Rx ded)(applies to Max OOP)
Dr. Office Visits (PCP)	100%[1]	60%[1,3]
Hospital Services - In-Patient	100%[1]	60%[1,3]
In-Patient Physician Fees	100%[1]	60%[1,3]
Emergency Room (copay waived if admitted)	100%[1]	60%[1,3]
Rx Benefits - Generic Rx Benefits - Formulary Brand	100% (combined Med/Rx ded)[1] 100% (combined Med/Rx ded)[1, 22]	60% (up to $500 per 30 day supply[18]) (combined Med/Rx ded)[1,3] 60% (up to $500 per 30 day supply[18]) (combined Med/Rx ded)[1,3, 22]
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000[2]	$6,550 / $13,100[2]
Out-Patient Surgical Facility	100%[1]	60%[1,3]
Ambulance (per trip)	100%[1]	60%[1,3]

Medical Benefits	EPO A ‡
Participating Health Plans	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group
Metal Tier	**Bronze**
Calendar Year Deductible*	$5,600 / $11,200[25] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$65 Copay (first 3 visits)[20] – 60%
Hospital Services - In-Patient	$1,000 Copay per admit
In-Patient Physician Fees	60%
Emergency Room (copay waived if admitted)	$400 Copay – 60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay / $20 Copay (ded waived)[27] $500 / $1,000 Ded – $60 Copay[27]
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700[26]
Out-Patient Surgical Facility	$500 Copay per admit – 60%
Ambulance (per trip)	60%[21]

(Footnotes on page 26)

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BENEFIT HIGHLIGHTS

BronzeHSP, HMO & EPO

Footnotes – Groups Beginning 7/1/18

- † A Health Savings Account (HSA)-qualified health plan is a high-deductible health plan that often offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified medical expenses with tax-advantaged dollars.
- ‡ This plan includes Infertility benefits; please see the California*Choice*® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.
- * 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. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
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. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
6. For Specialty drugs, please see plan specific EOC.
7. 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.
8. 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.
9. Deductible waived for first three non-preventive care visits.
10. In high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of Pocket Maximum.
11. 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 $2,700 for the 2018 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.
12. 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.
13. Deductible is waived for the first three non-preventive visits (combined for primary care specialist, urgent care, acupuncture and outpatient mental health or substance abuse disorder office visits).
14. 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 is 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 form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
15. 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.
16. Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
17. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behaviroal health and substance use disorder services).
18. Maximum member responsibility.
19. Covered in full after out-of-pocket maximum is met.
20. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic 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.
21. Medical emergency only.
22. 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.

(Footnotes continued on page 39)

OPTIONAL BENEFITS AND BUSINESS SOLUTIONS SUITE

With California*Choice*®, you and your employees have access to more than just medical benefits. You have access to valuable additional benefits like dental and vision, employer services, and employee discounts.

On the following pages you'll find a summary of the optional benefits and services and those available in our Business Solutions Suite at no additional cost. Each benefit and service available in the Business Solutions Suite is highlighted by a white briefcase:

Included in the Business Solutions Suite

THE PAGES THAT FOLLOW PROVIDE YOU WITH MORE INFORMATION ON:

Dental

Vision

Chiro

Life and AD&D

Hearing

Rx Discounts

Online HR Support

HSA Resource Center

Cal Perks Employee Discounts

COBRA Billing

Flexible Spending Accounts

Premium Only Plan (POP)

DENTAL

THREE GREAT WAYS TO OFFER EMPLOYEES DENTAL

Dentegra® Smile Club is included at no additional cost through the **Business Solutions Suite** and offers reduced fees for dental care services and a network of more than 20,000 providers.

SmileSaver℠ Dental 3000 and 1000 HMO benefits are available for a low monthly payment and offer FREE office visits, oral exams, X-rays and two cleanings per year! The Dental 3000 HMO can be added as a voluntary plan with no minimum employee participation.

Ameritas PPO benefits offer low deductibles that allow members to visit any dental provider they prefer, in- or out-of-network.

Plan Benefits	Dentegra Smile Club	SmileSaver Plan 3000	SmileSaver Plan 1000
Exams & Diagnostics	Coverage discounts equal 58% and are dental provider specific. Please see www.dentegrasmileclub.com/find-a-dentist for a list of dental providers and discounts.		
Initial Oral Exam		No charge	No charge
Periodic Oral Exam		No charge	No charge
Teeth Cleaning		No charge	No charge
X-Rays Bite-Wing (4 films)		No charge	No charge
Oral Surgery			
Removal of Uncomplicated Single Tooth		$10 copay	No charge
Removal of Impacted Tooth - partially bony		$50 copay	No charge
Removal of Impacted Tooth - completely bony		$65 copay	No charge
Restorative			
Cavities - Amalgam 1 Surface		$9 copay	No charge
Cavities - Amalgam 2 Surfaces		$14 copay	No charge
Endodontics			
Single Root Canal		$100 copay	$40 copay
Bi-Root Canal		$135 copay	$65 copay
Molar Root Canal		$185 copay	$95 copay
Periodontics			
Gingivectomy - Per Tooth		$30 copay	No charge
Periodontal Scaling & Root Planing (quadrant)		$26 copay	$20 copay
Crowns - Single Restoration			
Porcelain - Base Metal (posterior)		$225 copay†	$175 copay†
Full Cast Noble Metal		$115 copay†	$60 copay†
Orthodontics			
Child (maximum age 18)		$1,600 copay	$1,600 copay
Adult		$1,950 copay	$1,950 copay
Prosthodontics			
Complete Upper or Lower Denture		$120 copay	$70 copay
Partial Upper or Lower Denture		$110 copay	$50 copay

Note: Copays listed for plans 3000 and 1000 are for services performed by general dentists. Please consult the EOC for specialist copays.

† Cost of high noble metal (gold, etc.) may be charged extra when used. Not to exceed actual laboratory cost of metal.

Continued from previous page

	Ameritas PPO 3000		Ameritas PPO 3500		Ameritas PPO 4000		Ameritas PPO 5000	
Plan Benefits	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Annual Maximum Annual Deductible	$1,000 $50 (Max 3x/Fam)	$600 $100 (Max 3x/Fam)	$1,000[4] $50 (Max 3x/Fam)	$1,000[4] $50 (Max 3x/Fam)	$1,200[4] $25 (Max 3x/Fam)	$1,000[4] $75 (Max 3x/Fam)	$1,600[4] $25 (Max 3x/Fam)	$1,300[4] $75 (Max 3x/Fam)
Preventive Care Preventive Basic Major (12 Month Wait)[1] Endo/Perio	Ded. Waived 100% 80% 50% 50%	Ded. Waived 80% 80% 50% 50%[1]	Ded. Waived 100% 80%/90%/100%* 50% 80%	Ded. Applies 100% 80% 50% 50%[1]	Ded. Waived 100% 80%/90%/100%* 50% 80%	Ded. Applies 80% 80% 50% 50%[1]	Ded. Waived 100% 80%/90%/100%* 50% 80%	Ded. Applies 80% 80% 50% 50%[1]
"Fusion" Vision Reimbursement Annual Maximum	N/A		$100**		$100**		$100**	

Orthodontia[3]	Ameritas PPO 3000		Ameritas PPO 3500		Ameritas PPO 4000		Ameritas PPO 5000	
Maximum Age 18	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Orthodontia (24 Month Wait)[2] Annual Maximum Lifetime Maximum	Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered	50% None $1,000	50% None $1,000	50% None $1,000	50% None $1,000	50% None $1,000	50% None $1,000

DENTAL REWARDS® BY AMERITAS

Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed below, they can increase their next year's coverage by $250 and earn an additional $100 to $150 if they visit a network provider. For more information on Dental Rewards, please visit www.ameritas.com. (Dental Rewards is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)

	PPO 3000	PPO 3500	PPO 4000	PPO 5000
Carry Over Amount	N/A	$250	$250	$250
PPO Bonus	N/A	$100	$100	$150
Benefit Threshold	N/A	$500	$500	$750
Maximum Carry Over Amount	N/A	$1,000	$1,000	$1,000

* Submit one covered dental claim each year and your Basic procedures will advance to the 90% level the following year and to 100% on the third year.

** Annual maximum per calendar year to spend at any eye care provider. File claim with Ameritas Group for reimbursement.

† Plan 3000 and 3500 out-of-network claims are reimbursed at MAB. Plan 4000 and 5000 out-of-network claims are reimbursed at UCR.

1. 12 month waiting period applies. Waiting period will be waived for Groups with 10+ employees and 12 months continuous uninterrupted dental coverage on previous plan.
2. 24 month waiting period applies. Waiting period will be waived for Groups with 10+ employees and 24 months continuous uninterrupted orthodontia coverage on previous plan.
3. Orthodontia benefits are available to children only. Treatment must begin prior to their 19th birthday.
4. Annual maximum is a dental/vision combined benefit; you choose how to spend your maximum – it may be used toward dental and/or eye care expenses with maximum of $100 toward eye care expenses.

Please refer to the Evidence of Coverage for more detailed information.

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VISION

TWO VISION PROGRAMS, INCLUDING ONE AT NO ADDITIONAL COST

Vision discounts available through EyeMed Vision Care (**Vision One Eyecare Discount Program**) provided by Ameritas is included at no additional cost through the Business Solutions Suite and offers all California*Choice*® members discounts on frames, lenses, and eye examinations at any Sears, JCPenney, Target optical centers, LensCrafters, and participating Pearle Vision locations.

The Voluntary Vision Program offers comprehensive vision insurance benefits and prescription eyewear through a large network of doctors. Members get eye exams every twelve months with a $10 copay.

Vision One Eyecare Discount Program *(Included in the Business Solutions Suite at no added cost)*	**Voluntary Vision – EyeMed Provided by Ameritas**	**Voluntary Vision – VSP Provided by Ameritas**
All California*Choice* medical members and their dependents are eligible for immediate savings.	All California*Choice* members and their dependents may enroll in one of the voluntary vision plans if their employer elects to offer this coverage.	
Frames and Lens Savings: Up to 40% savings on frames, 40% on bifocals, and 15% on non-disposable contact lenses.	**Comprehensive Benefits:** members access quality vision care and prescription eyewear through a vast network of doctors. Out-of-network coverage is also available.	**Comprehensive Services:** VSP offers members access to the nation's largest network of eye care professionals. Out-of-network coverage is also available.
Exam Discounts: Many participating licensed independent Doctors of Optometry offer $5 discounts off their regular exam fees and $10 off their regular contact lens exam fees.	**Low Fee Exams:** In-network benefits offer a low copay of only $10 for an eye exam.	
Easy to Use: Simply visit a participating provider and present your ID card to verify your eligibility. To find the provider closest to you, visit www.eyemedvisioncare.com and click on EyeMed Vision Care Providers for EyeMed and visit www.vsp.com/ and click on Find a Doctor for VSP.		

Continued from previous page

	Vision One Eyecare Discount Program	Voluntary Vision–EyeMed Provided by Ameritas		Voluntary Vision–VSP Provided by Ameritas	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Examinations	**Participating Providers** $5 off routine exam $10 off contact lenses exam	$10 copay (1 per 12 months)	Up to $20 reimbursement	$10 copay (1 per 12 months)	Up to $45 reimbursement
Frames Any frame available at provider location	**Employee Cost** Up to 40% off of retail price	**In-Network Copay** Covered in Full up to $100 retail value (1 per 12 months)	**Out-of-Network Reimbursement** Up to $30 reimbursement up to $100 retail value (1 per 12 months)	**In-Network Copay** Covered in full up to $180 retail Value (1 per 12 months)	**Out-of-Network Reimbursement** Up to $70 reimbursement
Lenses		(1 per 12 months)		(1 per 12 months)	
Single Vision	$50	$10	Up to $20 reimbursement	$10	Up to $30 reimbursement
Bifocal	$70	$10	Up to $30 reimbursement	$10	Up to $50 reimbursement
Trifocal	$105	$10	Up to $40 reimbursement	$10	Up to $65 reimbursement
Standard-progressive (No line bifocals; Amount added to bifocal cost)	$65	$75	Up to $30 reimbursement	$55	Up to $50 reimbursement
Lens Options		(in addition to lens copayment above)		(in addition to lens copayment above)	
Polycarbonate	$40	$40	Not Covered	Covered in full for dependent children, $33 adults	Not Covered
Scratch-resistant coating	$15	$15	Not Covered	$17 - $33	Not Covered
Ultraviolet coating	$15	$15	Not Covered	$16	Not Covered
Solid or gradient tint	$15	$15	Not Covered	$15 - $17	Not Covered
Photochromic	20% off retail price	20% off of retail price	Not Covered	$31 - $82	Not Covered
Anti-reflective coating	$45	$45	Not Covered	$43 - $85	Not Covered
Contact Lenses	Save 15% off non-disposable contacts at nationwide locations and use the Vision One Contact Lens Replacement program for additional savings and convenience.	$10 (1 purchase per 12 months, in lieu of lenses and frames up to $100 retail value) **Contact Lens Fitting** Standard - Covered in Full Premium - 90% of charges (less $40 allowance)[1]	$50 reimbursement (1 purchase per 12 months, in lieu of lenses and frames up to $100 retail value) **Contact Lens Fitting** Standard - $40 reimbursement Premium - $40 reimbursement	$10 Copay (1 purchase per 12 months, in lieu of lenses and frames up to $180 retail value) **Contact Lens Fitting** Covered in full after member cost of up to $60	Up to $105 reimbursement (1 purchase per 12 months, in lieu of lenses and frames up to $180 retail value) **Contact Lens Fitting** 15% discount

1. Coinsurance is member responsibility.

CHIROPRACTIC AND ACUPUNCTURE

CHIROPRACTIC AND ACUPUNCTURE

Landmark Healthplan's Chiropractic and Acupuncture benefits are available for a low monthly fee and include affordable copays. Free personalized health coaching and education services are available through the WellCall program.

	Plan 1 + Chiro Only	Plan 2 + Chiro and Acupuncture
Office Visits Includes examinations, manipulation, conjunctive physiotherapy, and X-Rays	$15 Copay Per Visit Maximum - 20 Visits Per Plan Year	$15 Copay Per Visit Maximum - 20 Visits Per Plan Year (combined between Chiropractic and Acupuncture)
Acupuncture Treatment **Herbal Therapies***	Not Covered Not Covered	$15 Copay Per Visit $5 Copay Per Bottle (Maximum $500 per plan year)
Chiropractic Discounts Office Visits Examinations Adjustments Diagnostic Procedures & X-Rays Chiropractic Medical Appliances	In addition to the 20 office visits for $15 each, members will receive additional discounts through Landmark Healthplan's network of providers. These additional discounts are listed below, but are not limited to: minimum 25% discount for professional services	
Acupuncture Discounts Office Visits Examinations All Acupuncture Procedures (Includes electro-acupuncture, moxibustion, acupressure and cupping)	Not covered	Minimum 20% Discount for Professional Services

WellCall health coaching, education, and referral services

ChiroPlus members have free access to health coaches for:

- Weight management
- Smoking cessation
- Chronic conditions: asthma, back pain, or diabetes
- Having a healthy pregnancy
- Menopause

Additional WellCall services include:

- Free health and wellness books
- Health risk assessments
- Discounts to health clubs and spas
- Savings on health-related books, products, and equipment

To take advantage of this new service, ChiroPlus members may register** online at **www.wellcall.com** or call toll free (888) 493-5522

* Herbal Therapies are for oral ingestion or external application of naturally occurring botanical, animal, or mineral substances to support normal structure and function of the human body according to the principles of traditional Oriental medicine.

\+ Coverage is available for residents in California only.

** Password to register for initial log-in is "Landmark".

LIFE INSURANCE AND AD&D BY ASSURITY LIFE INSURANCE COMPANY

Assurity Life allows your employees to provide for their loved ones in the event of death. Accidental Death & Dismemberment (AD&D) benefits are also provided through this policy.

Coverage begins at a $10,000 minimum life insurance amount at initial enrollment ($5,000 minimum life insurance amount after initial enrollment) and increases based on the number of employees who enroll in the program.

Through the Living Benefits Provision, this benefit also provides a partial payment of the life insurance amount to policyholders who become terminally ill.

Policyholders may also exercise a Conversion Privilege – if you leave your job, are terminated, or otherwise end coverage – to convert your life policy to a private policy within 31 days of termination with no medical exam required.

Initial Enrollment

Employee Participation	Guaranteed Issue Maximum
1-10	$25,000
11-25	$50,000
26-50	$75,000
51-100	$100,000

After Initial Enrollment

Employee Participation	Guaranteed Issue Maximum Up to:
1-5	$5,000
6-10	$10,000
11-25	$25,000
26-100	$50,000

Note: A suicide exclusion applies to life insurance amount during the first two years and to AD&D at any time.

HEARING PROGRAM PRESCRIPTION DISCOUNTS

HEARING PROGRAM

INCLUDED IN THE Business Solutions Suite

California*Choice*® offers **EPIC Hearing Service Plan** (HSP) to you and your employees at no additional monthly cost through the Business Solutions Suite.

Savings On:

- Hearing tests
- Hearing aids
- Hearing aid batteries
- Ear protection
- Swim plugs
- Musician ear plugs
- Assistive listening devices
- Hearing aid cleaning supplies & accessories
- TV ears (amplifies & clarifies television)
- Telephone amplification
- Altering and signaling devices

Did you know?

- Hearing loss is the 3rd most chronic ailment in the nation
- 48 million Americans have some sort of hearing loss
- 65% with hearing loss are working adults 45 - 64

Advantages of EPIC HSP:

- Save up to 50% on brand name hearing aids
- All levels of technology and hearing aid styles
- Reduced costs on services & products
- National network of local ear physicians and audiologists
- Toll free telephone support
- Flexible payment plan
- No administrative forms or paperwork to fill out

PRESCRIPTION DISCOUNTS

INCLUDED IN THE Business Solutions Suite

The **California Rx Card® Program** is available to all California*Choice* members and offers prescription discounts up to 75%. There are no restrictions or participation guidelines to join.

Employees can download their card at **www.californiarxcard.com** to get discounts at participating pharmacies including:

- CVS
- Walgreens
- Vons
- Kmart
- Ralphs
- Sav-On Pharmacy
- Many other chain and independent pharmacies

ONLINE HR SUPPORT CENTER

INCLUDED IN THE **Business Solutions Suite**

You have 24-hour access to critical state and federal employment laws and a database of more than 2,500 questions and answers to common human resource issues. You can also download and customize Employee Handbooks, forms, and job descriptions at no additional cost as a part of the **Business Solutions Suite**.

The HR Support Center Offers You:

- Access to a document library with copies of Employee Handbooks, Company Policies, Job Descriptions, and HR Forms
- The latest employment laws as well as details about laws that have been updated
- Summaries of both state and federal laws that affect employers
- A database of questions and answers on subjects ranging from benefits and compensation, to labor relations and recruitment
- A glossary of commonly used HR terms and definitions
- A compilation of tools and information specific to Leave of Absence, Hiring, Performance Management, and Termination
- Great pricing on HR posters, books, and training videos
- A subscription to the monthly e-newsletter *HR Advisor* that is designed to keep you aware of the most current HR best practices and legal changes
- Articles written by HR Professionals with tips, information, and best practices to help you better manage your business and employees

HSA RESOURCE CENTER

INCLUDED IN THE **Business Solutions Suite**

Health Savings Accounts (HSAs) are an important part of a Consumer-Directed Health Plan, but many consumers are still unsure of how they work. All California*Choice*® members have access to the **HSA Resource Center** at calchoice.com. Employees can learn more about how HSAs work and their advantages, and they can even calculate potential savings over time.

As California's leading authority on employee choice benefits, California*Choice* has created a website that provides useful tools and information to help you determine whether an HSA is right for you. You'll also find a comprehensive Provider Search, easy to use Rx Search, and registered members can also access Choice Outcomes – hospital comparison data for procedures and costs.

PAYROLL SERVICES
EMPLOYEE DISCOUNTS

PAYROLL SERVICES POWERED BY HEARTLAND PAYROLL SOLUTIONS, INC.

Simplify your business by integrating **Heartland Payroll Solutions, Inc.** with your California*Choice*® benefits at no additional cost. Our Payroll Services work directly with your California*Choice* account, so any payroll changes you make are directly communicated in real time. This allows you to:

- Reduce overall administration
- Avoid overpayments of premiums on terminated employees
- Avoid missed coverage windows for new hires

Payroll Services Include:

- Direct Deposit
  A secure, convenient, and cost-effective alternative to paper checks
- Free Employee Payroll Portal (Intranet)
  Free Intranet provides employees with a secure platform to view and print pay stubs and W2s, update information, and post important company documents and procedures
- Outstanding Service
  A dedicated payroll specialist will be assigned to you
- Customized Payroll Reporting
  You'll receive a Payroll Summary, Payroll Register, Payroll Tax Report, and Employee Pay Stub with every payroll – and you can select a variety of standard payroll reports or create custom reports exactly the way you want
- Eliminate Liability
  Year-to-date conversion back to January. Taxes, quarterly, and annual reports. Guaranteed accuracy of timely deposit and filings two-hour call back guarantee or your payroll is free!

FREE EMPLOYEE DISCOUNTS FROM CAL PERKS

INCLUDED IN THE Business Solutions Suite

You and your employees will have access to **Cal Perks**, a free membership program providing great discounts on entertainment and attractions throughout California including:

- Theme parks
- Water parks
- Sporting events
- Museums
- Movies
- Golf
- Flowers
- Dry cleaning
- Hotels
- Warehouse store memberships
- Plus a whole lot more!

Log-in to calchoice.com for Current Discounts Available

CAL-COBRA AND FEDERAL COBRA BILLING

INCLUDED IN THE
Business Solutions Suite

With California*Choice*®, COBRA-related activities are included at no additional cost and employers have support in the following areas:

- COBRA participant invoicing
- Premium collection and remittance
- Tracking payment time frames
- Processing eligibility changes for non-payment scenarios

Cal-COBRA applies to employers with 1-19 employees;
Federal COBRA applies to employers with 20 or more employees.

FLEXIBLE SPENDING ACCOUNT (FSA)

INCLUDED IN THE
Business Solutions Suite

With an FSA, your employees set aside a portion of their salary, on a pre-tax basis, to pay for eligible FSA expenses. This process means they pay less in taxes while lowering your FICA contributions so your organization saves, too.

Available to groups with 15 or more employees.

Eligible Healthcare Expenses Include:

- Medical Expenses: copays, coinsurance, and deductibles
- Dental Expenses: exams, cleanings, x-rays, and braces
- Vision Expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Prescription drugs and insulin
- Professional Services: Chiropractic and Acupuncture
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.
- Hundreds of additional expenses

SECTION 125 PREMIUM ONLY PLAN (POP)

INCLUDED IN THE
Business Solutions Suite

Premium Only Plans allow your employees to pay their share of health care premiums (health and dental) with pre-tax dollars, allowing them to take home more money. And when your taxable payroll decreases, you save money by reducing FICA and Workers' Compensation expenses.

ADDITIONAL FOOTNOTES

Groups Beginning 7/1/18

GoldHMO

(Footnotes continued from page 16)

17. 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.
18. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
19. 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.
20. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
21. 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.
22. Medical emergency only.
23. 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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
24. 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.

GoldPPO

(Footnotes continued from page 17)

‡ This plan includes Infertility benefits; please see the California*Choice*® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

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

1. 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.
2. 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; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
3. 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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
4. Amount listed is maximum paid by Anthem.
5. Medical emergency only.

GoldPPO

(Continued)

6. 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.

SilverHMO & HSP

(Footnotes continued from page 21)

16. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
17. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
18. 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.
19. 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.
20. 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.
21. Maximum member responsibility.
22. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
23. 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.
24. Medical emergency only.
25. 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; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
26. 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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
27. 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.
28. $2,000 Self only enrollment, $2,700 for any one member within a Family enrollment. $4,000 for an entire family. Does not apply to preventive care.

SilverHMO & HSP

(Continued)

29. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
30. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

SilverPPO & EPO

(Footnotes continued from pages 22)

5. Medical emergency only.
6. Maximum member responsibility.
7. Deductible applies depending on who is covered under the plan at the time service is rendered - Subscriber only: $2,000 individual deductible; or Subscriber and Family coverage: $2,700 individual and $4,000 family deductible. For family deductible, for any given member, cost share applies either after he/she meets the per member deductible, or after the entire family deductible is met. The per family deductible can be met by any combination of amounts from any member, however no one member may contribute any more than his/her per member deductible toward the family deductible.
8. 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.

BronzeHSP, HMO & EPO

(Footnotes continued from page 26)

23. In high deductible health plans (HDHPs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.
24. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual.
25. 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; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
26. 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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
27. 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.

NOTES

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