CaliforniaChoice®

Your Health. Your Choice.®

member enrollment guide

Groups Beginning 7/1/20

Anthem BlueCross · Health Net · Kaiser Permanente · oscar · Sharp Health Plan · Sutter Health Plus Your Health Plan · UnitedHealthcare · Western Health Advantage

The flexibility to choose from a wide range of plans

Select from California's leading health insurance plans. With HMOs, EPOs, and PPOs, you can choose a plan with the benefits and coverage that work best for you and your family.

Great service and easy-to-manage benefits

Access the forms you need, add or delete dependents, and easily find doctors and hospitals in your plan on a single website. And if your family's health needs change from year to year, it's easy to select a new plan during your annual renewal period.

Programs that help you stay healthy and save

You'll discover outstanding customer service and great programs that help you and your family manage your health, stay healthy, and save money on wellness, family activities, and the products you use every day.

DISCOVER THE ADVANTAGES

The benefits listed in this brochure were collected from all plans participating in the CaliforniaChoice® Program and are accurate to the best of our knowledge at the time of print. If the information in this brochure differs from the information in the SBC (Summary of Benefits and Coverage), EOC (Evidence of Coverage) or COI (Certificate of Insurance), the EOC or COI applies.

TABLE OF CONTENTS

WELCOME TO CALIFORNIACHOICE ®

Healthcare for the Way We Live®

CONGRATULATIONS!

Your employer has decided to offer health insurance coverage through CaliforniaChoice, giving you more options than any other program available in California.

Anthem BlueCross

Health Net

KAISER PERMANENTE

oscar

SHARP HEALTH PLAN

Sutter Health Plus Your Health Plan

UnitedHealthcare

Western Health Advantage

What is CaliforniaChoice?

CaliforniaChoice is a health insurance program that allows you to choose from multiple health plans and benefit options. With over 20 years of experience providing health benefits to Californians, we know you'll find our service and health plan selection is second to none.

CaliforniaChoice gives you the freedom to choose between multiple health plans, the doctors you prefer, and the coverage that will help you and your family manage your health and get the care you need, when you need it.

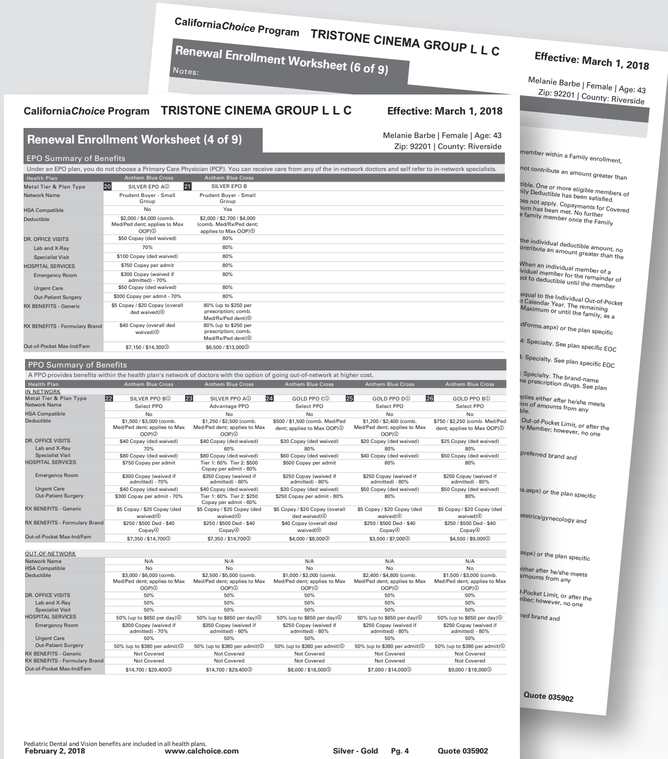
Under the Affordable Care Act (ACA), health benefits are divided into four metal tiers: **Bronze, Silver, Gold, and Platinum**. Each tier offers a variety of plan choices. Your employer will advise you which of the three CaliforniaChoice metal tier options is available to you:

- **TRIPLE TIER** – **Offer more choices!** Employees have access to the health plans and benefits available in **three neighboring tiers**.
- **DOUBLE TIER** – Offer employees access to the health plans and benefits available in **two neighboring tiers**.
- **SINGLE TIER** – Offer employees access to the health plans and benefits available in **a single tier.**

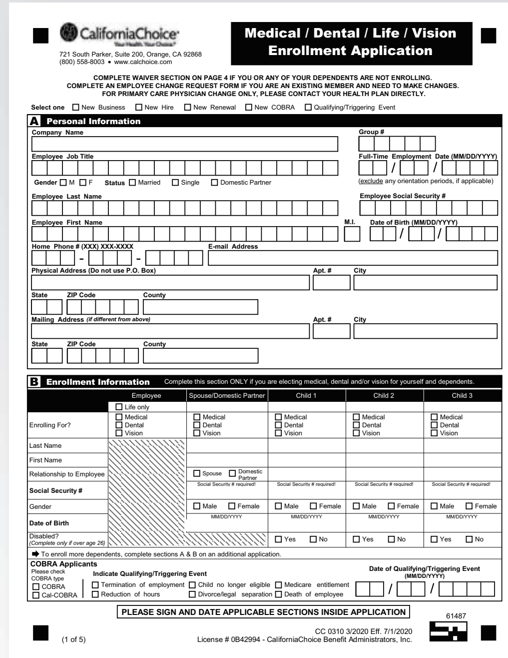
What you have access to with CaliforniaChoice

- A great selection of HMO, EPO, and PPO benefit plans to choose from
- A choice of eight of California's leading health plans
- DHMO and PPO dental plan options*
- Vision, chiropractic/acupuncture, and life insurance services*
- The flexibility to change health plans during your annual renewal period
- Outstanding customer service including a 24-hour interactive voice response line to help answer your questions
- A comprehensive website where you can manage benefits, add family members, or find doctors and hospitals
- A free prescription savings card
- Discount programs that let you save on health products, fitness memberships, entertainment, theme parks, movies, and more

* Availability based on benefits selected by your employer.



Personalized Enrollment Worksheet



Enrollment Application

Tools You'll Need to Enroll

Gather these items to help you get started.

This guide will help you select and enroll in a health plan with the benefits and coverage that work best for you and your family. The pages shown above are included in your enrollment packet. Locate these forms and use them to complete your enrollment.

It's easy to choose the right benefits with CaliforniaChoice® because we lay it all out for you – from how much your employer is contributing to your benefits, to how much each benefit is for you and/or your dependents to enroll.

TIP ONLINE DOCTOR SEARCH

An important step in enrollment is selecting a primary care doctor who participates in your health plan's network. You can use the CaliforniaChoice online Provider Search to find out which health plans your current doctor accepts or find a new physician in your plan with a convenient location for you and your family members.

MANAGE YOUR BENEFITS ONLINE

CaliforniaChoice® makes it easy to manage your benefits online, anytime – 24 hours a day, 7 days a week.

During enrollment, you can:

- Compare benefit plans
- Find a doctor, specialist, or hospital
- Verify prescription drug coverage
- Download forms

Once enrolled, you can:

- Review your benefits
- Add or delete a dependent
- Compare hospital pricing and performance
- Sign up for a free prescription savings card
- Access Cal Perks online discount program

Visit www.calchoice.com today!

YOUR BENEFIT CHOICES

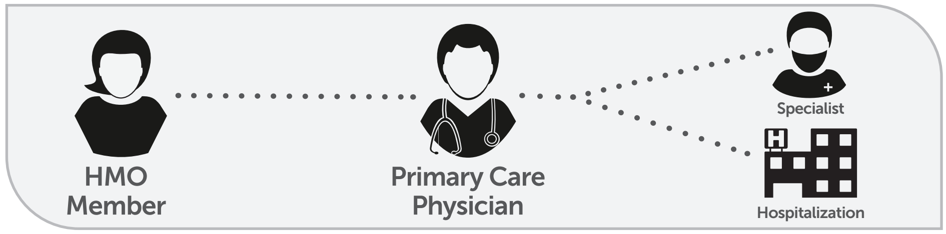
CaliforniaChoice® offers you a variety of plan types to choose from–helping you balance your health needs with your budget.

> An HMO plan provides a Primary Care Physician (PCP) who manages your overall health care while an EPO plan means you manage your own care, self-referring to doctors within your plan's network of physicians. With a PPO plan you also manage your own care, but choose doctors and specialists from both inside and outside the provider network.

Health Maintenance Organization (HMO)

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in-network through your Primary Care Physician (PCP).

- First select a PCP. Referrals to hospitals and specialists are managed by your PCP.
- You pay a low copayment for each office visit.



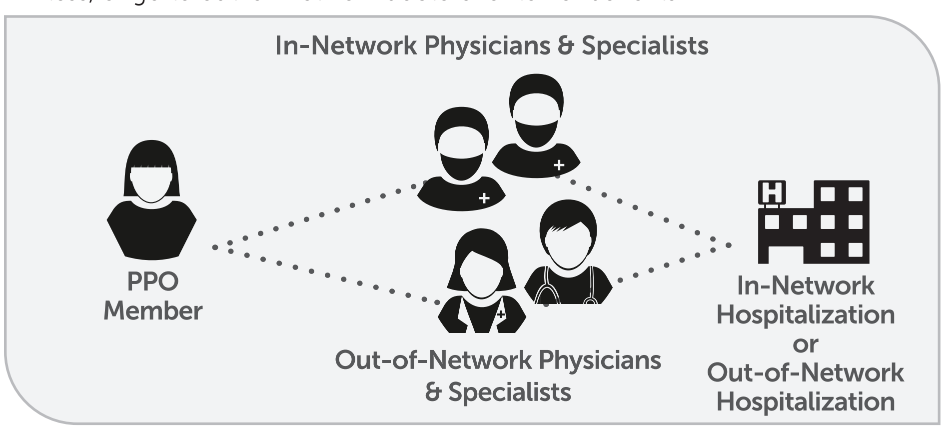
Exclusive Provider Organization (EPO)

Under an EPO plan, you do not choose a Primary Care Physician (PCP). You can receive care from any of the in-network doctors and self-refer to in-network specialists.

Preferred Provider Organization (PPO)

A PPO provides benefits within the health plan's network of doctors with the option of going out-of-network at higher costs.

- PPOs do not require you to select a PCP.
- You can self-refer to specialists and see any doctor you'd like, but your benefits are not as rich when you see out-of-network doctors.
- You can receive care from two levels of in-network doctors where you pay less, or go to out-of-network doctors for lower benefits.



FINDING THE RIGHT PLAN FOR YOU

The key to finding a health and benefit plan that fits your family is thinking about what your family needs. Consider options like where you want to receive care, how involved you want to be in managing your own care, or how important it is to choose your own doctors. Discovering what's most important and putting it at the top of your list can help you choose the right plan.

I want to choose my doctors.

You want to be able to use the doctors you choose, when you choose to see them, in a location that's convenient to you.

CONSIDER A PPO PLAN

PPO plans let you use both in-network and out-of-network providers whenever you choose.

I'd like to manage my own care.

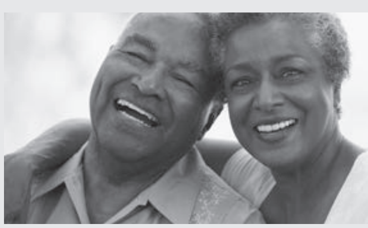
You're looking for an affordable plan that offers a wide network of doctors – and lets you see the doctors you choose.

AN EPO MAY BE RIGHT FOR YOU

EPO plans offer the convenience and affordability of a wide network of physicians and hospitals who contract with your health plan, while allowing you to self-refer to any of the plan's in-network specialists.

I want a doctor to manage my care.

You want a Primary Care Physician (PCP) who will manage your care and refer you to the specialists you need.



CONSIDER AN HMO PLAN

HMO plans provide a PCP who will manage your care and refer you to the specialists you need to see.

I have a health condition.

You or someone in your family is managing a chronic health condition and needs access to health coaching and health management programs.

LOOK FOR HEALTH MANAGEMENT BENEFITS

- HMO plans offer a PCP to help manage your health and refer you to the specialists you need.
- Look for plans with health coaching and disease management programs.

HEALTH PLAN CHOICES

Choosing the health plan that's right for you is an important part of getting access to the doctors and hospitals you want, making the most of your healthcare budget, and helping you and your family live your healthiest lives.

Trust in Anthem Blue Cross to make a difference

Leading our members to better health is what we at Anthem Blue Cross focus on each and every day. Anthem offers flexible, innovative health benefits, improvement programs, and simplified administration services that make health care easier than ever to use. We're committed to providing the best value for health care coverage dollars and helping to ensure our members have access to affordable health benefits.

Anthem Benefits Overview

- One of the largest PPO networks in the country with access to thousands of doctors and specialists; more than 60,800 doctors and specialists in CA
- Contracted with more than 90% of hospitals in CA, including 400 acute care hospitals
- Strong network contracting with an average 60% hospital discount and 48% average provider discount
- Cost and care finder tool online and via our mobile app - compare costs for common services and procedures based on specific benefits; check the quality of providers through ratings and member reviews
- PayForward – exclusive to Anthem members, this program gives you an opportunity to earn cash back when shopping at thousands of retailers
- Special Offers program for discounts on healthy products and services
- Wellness programs and tools to keep you active and fit

Local. Affordable. Easy.

Make this your year for health where with the people who put health first. Health Net makes it simple with plan choices tailored to fit your health, your life, and your budget. With 40 years of excellence in the health industry, you can count on Health Net for all the benefits you need.

Health Net Benefits Overview

- Easy-to-understand benefits and predictable costs
- A variety of Networks where you will find trusted doctors, medical groups, and hospitals in your community
- Decision Power Wellness Coaching
- Nurses available 24/7 by phone
- Health Net Mobile makes it easier to get things done
- Access Teladoc *telehealth services* 24 hours a day, 7 days a week, with board-certified doctors available by phone, mobile app, or web
- Access Heal *on-demand doctor house calls* for Sick/Urgent care services only with any of our HMO plans (Available in select urban areas)
- Strength and stability. Centene, Health Net's parent company, is a Fortune 100 Company (#51 on the Fortune 100 List). Health Net supports your health through every stage of life – just like we've been doing for 40 years
- People who are making health care work for you

Good health is in your hands.

Kaiser Permanente was one of the first health programs to offer comprehensive healthcare services on a prepaid basis. The same innovative spirit also drives the nation's largest nonprofit health care organization today – a nonprofit health plan that is guided by physicians and focused on providing high quality care to members.

Kaiser Permanente Benefits Overview

- 8.5 million members in California, 11.8 million total members in 8 states and the District of Columbia
- In California more than 16,000 physicians provide care at over 450 medical offices and 36 hospitals
- Choose your personal physician and change doctors for any reason
- We select our doctors carefully. In California, only one of every ten applicants is chosen to become a Kaiser Permanente physician
- "Excellent" ratings from the National Committee for Quality Assurance (NCQA), the leading reviewer of health plan quality

Hi, we're Oscar.

Oscar Health is the country's first technology-driven health insurer focused on improving the member experience through easy, personalized service. Oscar for Business was launched to bring the same Oscar experience that individuals already love to the employer market.

Oscar Benefits Overview

• Full access to our network of first-rate providers that includes top health systems like UCLA, USC Keck, Hoag, Huntington, and others – in fact, we have 4 of LA's top 5 hospitals (as ranked by US News & Reports 2018) in-network!

• No referrals required – ever. Being required to get a primary care physician first in order to see a specialist can waste your time and money. With Oscar, you can go directly to any specialist in your network—no roadblocks!

• A dedicated Concierge team, made up of care guides and a nurse who can answer questions, help you save money, and find you a doctor. Each member gets assigned his or her very own Concierge team, which means you talk to the same people every time you have questions — no more anonymous call centers!

• Unlimited Doctor on Call. Talk to a board-certified doctor within 15 minutes, 24/7 for medical advice. They'll even send prescriptions straight to your pharmacy! All plans offer telemedicine at no to low cost ($15) copay!

• Oscar's industry-leading mobile app makes it easy to manage benefits, find great care, and see everything in one place. You can easily search for doctors in your network, track your deductible, understand your claims, see lab results and prescriptions, access your digital member ID card, message your Concierge team, talk to a doctor via Doctor on Call, and more!

Our consumer-centric approach to health care is working: our customer satisfaction rating (aka Net Promoter Score) is 3x higher than the industry average for health coverage companies.

Want to learn more about what Oscar offers? Visit us at hioscar.com.

CaliforniaChoice® offers you benefit plans from the leading health plans in California and throughout the nation, to help you find a plan that's convenient, affordable, and offers the benefits that work for you.

Welcome home.

Sharp Health Plan is the only local, commercial health plan, serving San Diego since 1992. As a non-profit company, Sharp Health Plan gives back to the community by providing access to affordable health care of the highest quality, serving a variety of organizations ranging from small businesses to large employers to municipalities.

Sharp Health Plan Benefits Overview

- HMO Platinum, Gold, Silver, and Bronze plans
- High Deductible Bronze HMO and HSA plans
- High performance health care network with more than 600 primary care physicians, 1,100 specialists, and 13 local hospitals
- Sharp Nurse Connection after hours nurse advice line
- Global emergency service program operated by Assist America
- Treatment for minor illnesses and injuries available at CVS Minute Clinics nationwide

Affordability. Convenience. Quality.

Not-for-profit Sutter Health Plus offers competitively priced HMO health plans in the Greater Central Valley, Sacramento and Bay Area. When you choose Sutter Health Plus, you gain access to a high-quality provider network that includes many of Sutter Health's nationally respected and recognized hospitals, doctors and other health care services—all at an affordable price.

Sutter Health Plus Benefits Overview

- Competitively priced products that give members access to a network of providers
- Convenient locations within our service area for primary care, specialty care, X-ray and diagnostic imaging, lab, hospital services, etc.
- Mail-order pharmacy program as well as conveniently located retail pharmacies
- My Health Online (not offered by all providers) to schedule appointments, email doctors, view test results and access your records
- Coverage for emergency and urgent care anywhere in the world
- Welcome calls to help new and returning members better understand medical benefits and coverage and assist in facilitating initial appointments
- A 24/7 nurse advice triage line

Quality.

UnitedHealthcare of California provides access to quality care and helps you manage your family's health care costs. Our large California HMO network includes local physicians and health care professionals in your community. With a combination of benefits, quality care, wellness programs to help keep you and your family healthier and award-winning customer service[1] – we are here for you – making UnitedHealthcare the smart choice for your family's health care coverage needs.

UnitedHealthcare Benefits Overview

- A broad network of quality local doctors and hospitals
- A member website, uhcwest.com providing online tools and resources
- Health and Wellness Programs
- Preventive care for covered family members
- Fitness reimbursement program

Quality Health Care that Meets Your Needs.

Since 1996 Western Health Advantage has been a reliable partner in northern California communities. Through our HMO network WHA serves employers and individuals in Sacramento, Yolo, Solano, Napa, Sonoma, Marin counties and parts of Placer and El Dorado counties. Supporting the communities where we live and work is one of WHA's core values.

Western Health Advantage Benefits Overview

- Affordable coverage with many choices
- A network of thousands of local, trusted doctors and specialists
- Responsive customer service staffed by local, real people
- MyWHA Wellness program with online health and wellness tools
- Discounts on gym memberships
- Nurse24 advice line with registered nurses 24/7
- Worldwide urgent and emergency coverage with Assist America

[1] UnitedHealthcare's Advocate4Me service model, which leverages innovative tools and technology to simplify and personalize care for members, received a Stevie award in the Sales & Customer Service category at the 2015 American Business Awards.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health Plan coverage provided by or through UHC of California DBA UnitedHealthcare of California. OptumRx or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

HOW TO **ENROLL**

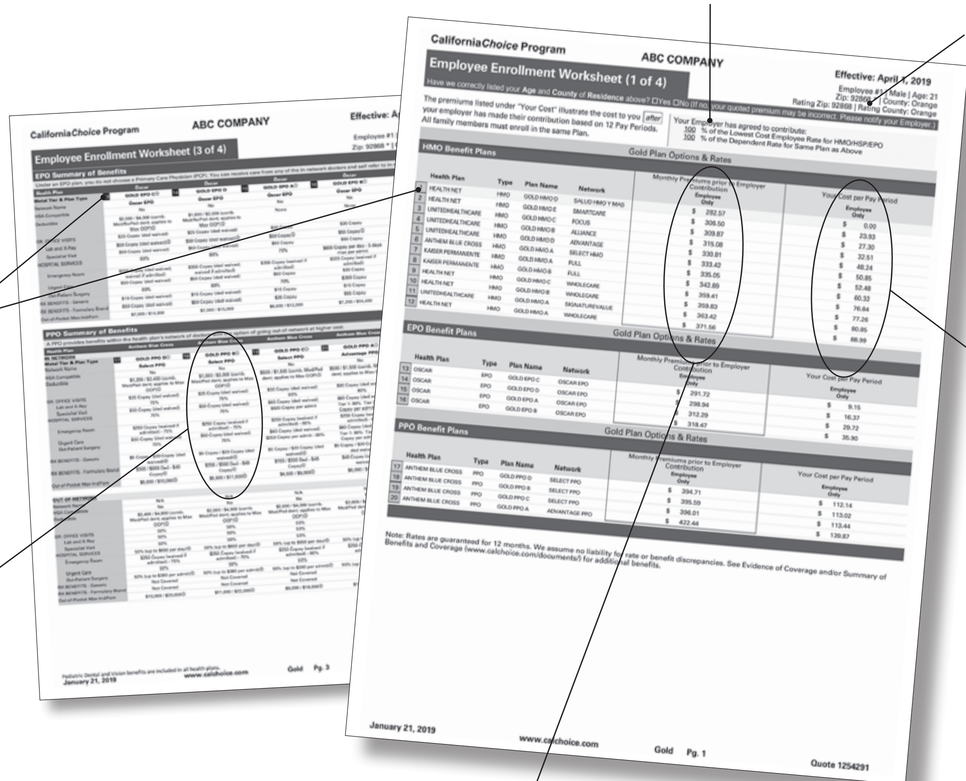
1 Review your Personalized Enrollment Worksheet

Your Personalized Enrollment Worksheet is a great tool because it shows you all of your benefit choices and the cost associated with each option after your employer's contribution has been applied. This means what you see on your Worksheet is exactly what you'll pay each pay period.

You can also see the costs associated with adding a spouse and/or dependents to your coverage.

Your Employer's Contribution
Your employer's contribution is clearly highlighted.

Verify your age, home and employer ZIP Code



Numbered Plans
Available plans numbered so they can be easily referenced on the following benefit summary pages.

Detailed Benefit Summaries
Each health plan's key benefits, including deductibles, doctor co-pays, emergency room visit co-pays, etc, are broken down so that you can select the plan that best fits your budget and health care needs.

Your Cost
The premiums listed illustrate the cost to you after your employer has made their contribution based on your pay period. You may choose this plan or select any of the other plan options that fit your needs.

Health Plans Sorted by Cost
Health coverage options are sorted by monthly premium, from lowest to highest cost, according to plan type (HMO, EPO, and PPO).

Use your Personalized Enrollment Worksheet to:

COMPARE HEALTH PLAN COSTS and review your options for copayments, premiums, and out-of-pocket payments.

AND

REVIEW YOUR BENEFIT OPTIONS to determine which health plan provides the benefits and coverage you need.

HOW TO ENROLL

2 Choose your doctor

Before you finalize your choice of plans, visit the CaliforniaChoice website to select a Primary Care Physician who participates in the provider network for the plan you are considering.

FIND A NEW DOCTOR – OR LOOK UP YOUR CURRENT DOCTOR

Whether you have a current doctor you would like to get care from, or you're looking for a new Primary Care Physician, CaliforniaChoice® makes it easy to quickly look up doctors and specialists in the network for the health plan you select.

Our CaliforniaChoice Provider Network lists all of the physicians affiliated with each of our health plans and networks.

- Go to www.calchoice.com
- Click on "Provider Search" in the top navigation bar
- Select "Medical Carriers"
- Enter the city or ZIP Code in which you wish to find a doctor
- Indicate your gender preference
- Select your insurance carrier from the drop-down list
- Click on the green "Find Your Doctor" box

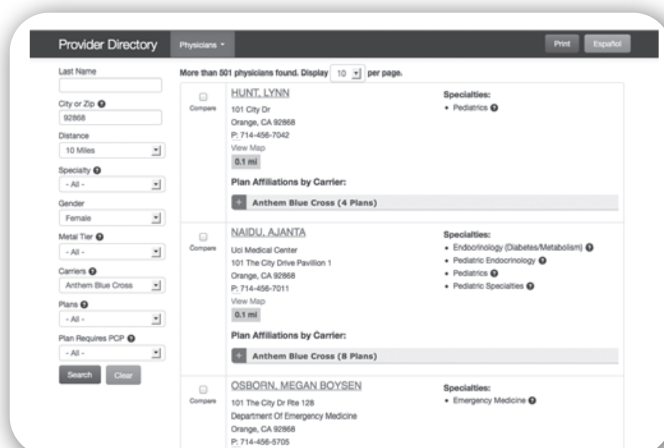
The Provider Directory will display a list of doctors matching your selected criteria. You can narrow your search further by:

- Entering the last name of the doctor
- Selecting the distance from your city or ZIP Code entry
- Specifying a medical specialty
- Choosing your health plan Metal Tier
- Selecting "yes" or "no" on whether the plan requires a Primary Care Physician

YOU CAN ALSO FIND OUT WHAT PLANS COVER SPECIFIC DRUGS

If you or your insured dependents need a specific drug, you can compare prescription drug coverage by using the online formulary, **CaliforniaChoice Rx Search,** on www.calchoice.com. Just click on "Rx Search" in the top navigation bar.

You can search alphabetically, by brand and generic name, by therapeutic class, or by health condition. And you can view a list of the health plans and plan designs offering coverage for your specific prescription drugs.

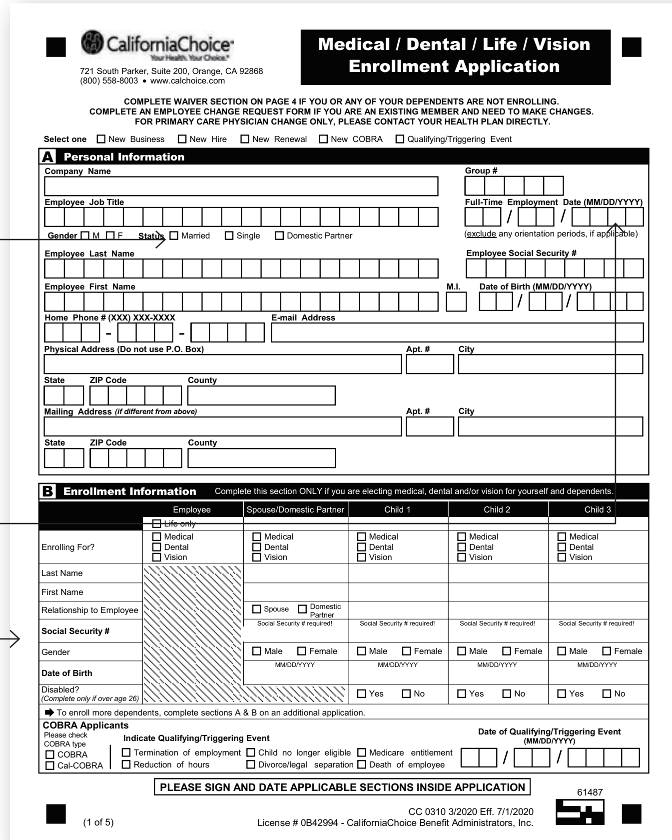


If you are in the middle of treatment AND your current physician is not contracted with the Health Plan you wish to select, please contact our Customer Service Center at 800.558.8003 for further information and assistance.

HOW TO ENROLL

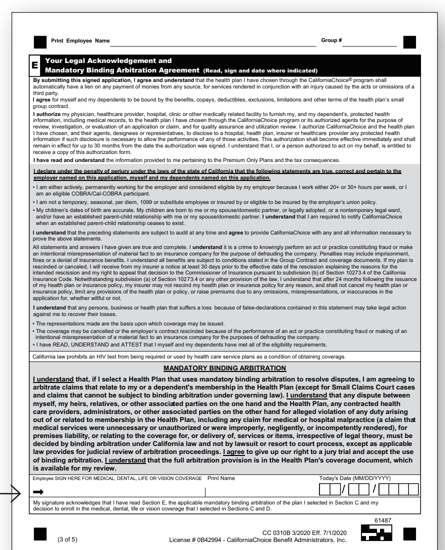
3 Complete your Enrollment Application

Your Enrollment Application will only take a few minutes to complete. We recommend once your application is completed, you go over it one last time to make sure all of the required fields are completed.



REMEMBER TO:

- Select marital status
- Include date of hire
- Include Social Security Numbers (SSN) for dependents
- Sign the reverse side of your Application to accept coverage



FREQUENTLY MISSED SECTIONS

- Children's SSN
- Disabled dependent box
- Provider ID#
- Current Patient (if HMO)
- Dentist chosen (if DMO)
- Life beneficiary (if Life Insurance offered)
- Date of hire
- Marital status

4 Adding dependents

COVERAGE FOR A SPOUSE AND CHILDREN

If you are enrolled and have a spouse and/or children, they may also be eligible for coverage.

SPOUSE: Must be legally married to you in order to be eligible for coverage through the CaliforniaChoice® program.

CHILDREN: See below.

MEDICAL, VISION, CHIRO, AND SMILESAVER DENTAL DEPENDENT ELIGIBILITY:

- Born to, a step-child or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse, or domestic partner
- Under age 26 (unless disabled, disability diagnosed prior to age 26)

AMERITAS DENTAL DEPENDENT ELIGIBILITY:

- Born to, a step-child or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse, or domestic partner
- Financially dependent upon the employee per IRS guidelines
- Unmarried or not involved in a domestic partnership
- Under age 26 (unless disabled, disability diagnosed prior to age 26)

DISABLED DEPENDENTS: Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday.

- You are not required to extend coverage to either your spouse or your dependent children. If you do not wish to do so, you must check the appropriate boxes and sign the **Waiver Form**, stating that you decline dependent coverage.
- Any family member enrolling for coverage through the CaliforniaChoice Program must choose the same participating health plan and benefit plan, although each is free to choose a different Primary Care Physician (PCP).

DOMESTIC PARTNER COVERAGE REQUIREMENTS

The employee and partner must fall into all of the following categories:

- Both have filed a duly executed Declaration of Domestic Partnership with the Secretary of State and will provide copies to CaliforniaChoice within 60 days of its issue
- Agree to notify CaliforniaChoice immediately upon termination of domestic partnership

Domestic Partners are required to submit a state-stamped copy of the Declaration of Domestic Partnership from the California Secretary of State within 60 days of issuance. If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted. Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance.

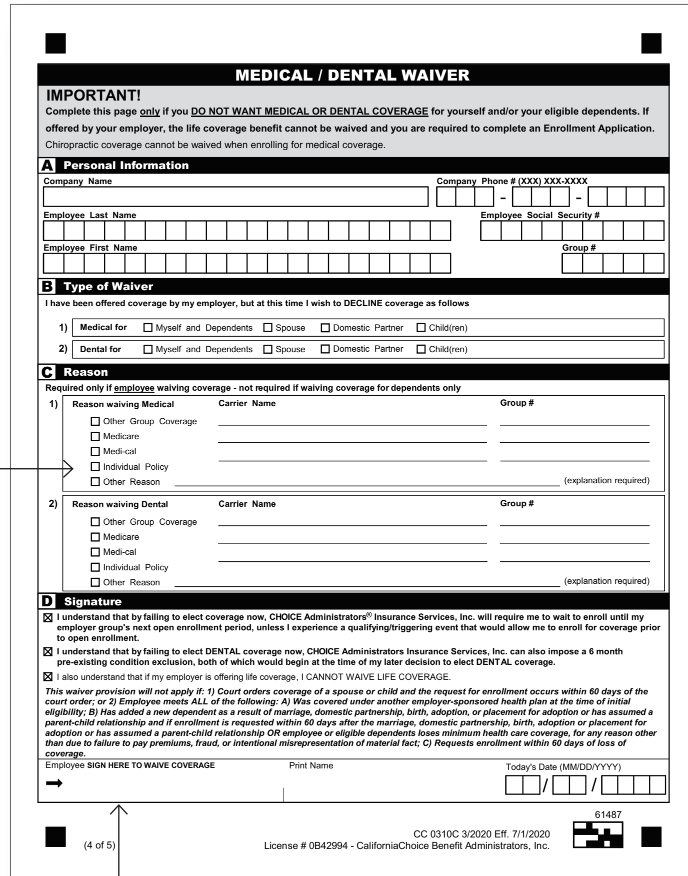
HOW TO ENROLL

5 Complete your Waiver Form

By filling out a Waiver Form, you are telling us that either you or one of your family members would like to waive coverage.

REMEMBER TO:

Check-off the correct reason for waiving coverage



MEDICAL / DENTAL WAIVER

IMPORTANT!

Complete this page only if you DO NOT WANT MEDICAL OR DENTAL COVERAGE for yourself and/or your eligible dependents. If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.

Chiropractic coverage cannot be waived when enrolling for medical coverage.

A Personal Information

Company Name

Company Phone # (XXX) XXX-XXXX

Employee Last Name

Employee Social Security #

Employee First Name

Group #

B Type of Waiver

I have been offered coverage by my employer, but at this time I wish to DECLINE coverage as follows

1) Medical for ☐ Myself and Dependents ☐ Spouse ☐ Domestic Partner ☐ Child(ren)

2) Dental for ☐ Myself and Dependents ☐ Spouse ☐ Domestic Partner ☐ Child(ren)

C Reason

Required only if employee waiving coverage - not required if waiving coverage for dependents only

1) Reason waiving Medical — Carrier Name — Group #

☐ Other Group Coverage
☐ Medicare
☐ Medi-cal
☐ Individual Policy
☐ Other Reason (explanation required)

2) Reason waiving Dental — Carrier Name — Group #

☐ Other Group Coverage
☐ Medicare
☐ Medi-cal
☐ Individual Policy
☐ Other Reason (explanation required)

D Signature

☒ **I understand that by failing to elect coverage now, CHOICE Administrators® Insurance Services, Inc. will require me to wait to enroll until my employer group's next open enrollment period, unless I experience a qualifying/triggering event that would allow me to enroll for coverage prior to open enrollment.**

☒ **I understand that by failing to elect DENTAL coverage now, CHOICE Administrators Insurance Services, Inc. can also impose a 6 month pre-existing condition exclusion, both of which would begin at the time of my later decision to elect DENTAL coverage.**

☒ I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 60 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Has added a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption or has assumed a parent-child relationship and if enrollment is requested within 60 days after the marriage, domestic partnership, birth, adoption or placement for adoption or has assumed a parent-child relationship OR employee or eligible dependents loses minimum health care coverage, for any reason other than due to failure to pay premiums, fraud, or intentional misrepresentation of material fact; C) Requests enrollment within 60 days of loss of coverage.

Employee **SIGN HERE TO WAIVE COVERAGE** → | Print Name | Today's Date (MM/DD/YYYY)

61487

(4 of 5) CC 0310C 3/2020 Eff. 7/1/2020
License # 0B42994 - CaliforniaChoice Benefit Administrators, Inc.

Sign here if you are waiving coverage for yourself and/or your dependents

IMPORTANT THINGS TO REMEMBER WHEN WAIVING COVERAGE

- If you waive coverage for medical and/or dental benefits, you will have to wait for your company's renewal period in order to be eligible again.
- If you choose to enroll in medical and/or dental benefits, but you want to waive an eligible spouse or dependent child, a Waiver Form must be filled out.
- By failing to elect coverage now, CHOICE Administrators® Insurance Services, Inc. can impose up to a 12-month period of exclusion, which would begin at the time of the individual's later decision to elect coverage.

MEDICAL BENEFIT SUMMARIES

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO C	HMO D
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	WholeCare	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,200 / $4,400 [9]	$2,250 / $4,500	$2,250 / $4,500 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$15 Copay	$30 Copay	$30 Copay
Specialist Visit (SPC)	$30 Copay	$50 Copay	$50 Copay
Laboratory	$15 Copay [18]	$20 Copay	$20 Copay
X-Ray	$25 Copay [18]	$50 Copay	$50 Copay
MRI, CT and PET (office setting)	$100 Copay per test [20]	$250 Copay per procedure	$250 Copay per procedure
Hospital Services – In-Patient	$250 Copay per day – 3 days max per admit	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$200 Copay	$250 Copay	$250 Copay
Urgent Care	$15 Copay	$30 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay $200 Copay	 $150 Copay $150 Copay [2]	 $150 Copay $150 Copay [2]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$30 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$150 Copay [15]	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [16] $35 Copay [16] $70 Copay [16] 70% (up to $250 per prescription [14]) (prior auth. required) [12, 16]	 $5 Copay [6, 7] $20 Copay [6, 7] $30 Copay [6, 7] 70% (up to $250 per prescription [14]) (prior auth. required) [6, 7]	 $5 Copay [6, 7] $20 Copay [6, 7] $30 Copay [6, 7] 70% (up to $250 per prescription [14]) (prior auth. required) [6, 7]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [16]	Applicable Rx Copay [6,7]	Applicable Rx Copay [6, 7]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	$50 Copay	$50 Copay
Chemotherapy	$30 Copay	100%	100%
Chiropractic (20 visits max per year)	$15 Copay (20 visits max per benefit period) [17]	Not Covered	Not Covered
Acupuncture	$15 Copay	$10 Copay [1]	$10 Copay [1]
Physical, Occupational, Speech Therapy	$15 Copay [18]	$30 Copay [18]	$30 Copay [18]
Rehabilitative & Habilitative Services and Devices	$15 Copay [18]	$30 Copay [18]	$30 Copay [18]
Home Health Care (Max 100 visits per year)	$30 Copay (Max 100 visits per benefit period) [11]	$30 Copay	$30 Copay

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO C	HMO D
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	WholeCare	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$100 Copay per day – 3 days max per admit [19]	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$100 Copay	70%	70%
Mental Health In-Patient Out-Patient (office visit)	 $250 Copay per day – 3 days max per admit $15 Copay	 $500 Copay per day – 4 days max [5] $30 Copay [5]	 $500 Copay per day – 4 days max [5] $30 Copay [5]
Drug/Substance Abuse In-Patient (Detox Only)	 $250 Copay per day – 3 days max per admit	 $500 Copay per day – 4 days max	 $500 Copay per day – 4 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $15 Copay [13] Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% 100% (in lieu of eyeglasses) 100% 1 per calendar year	 EyeMed [10] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [10] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime None Combined with Medical 100% 100% 50% 50% 50%	 Dental Benefit Providers [8, 10] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 10] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. Must be medically necessary.
2. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types..
3. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
4. See plan specific EOC for information on preventive services.
5. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
6. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
10. Pediatric dental and vision are included on all plans.
11. Limited to 100 4-hour visits per benefit period.
12. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
13. Evaluation only.
14. Maximum member responsibility.
15. Medical emergency only.
16. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
17. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
18. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
19. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
20. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Services	HMO E	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,250 / $4,500	$3,000 / $6,000 [17]	$4,500 / $9,000 [17]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$10 Copay	$15 Copay
Specialist Visit (SPC)	$50 Copay	$20 Copay	$30 Copay
Laboratory	$20 Copay	$20 Copay	$15 Copay
X-Ray	$50 Copay	$40 Copay	$30 Copay
MRI, CT and PET (office setting)	$250 Copay per procedure	$150 Copay per procedure	$75 Copay per procedure
Hospital Services – In-Patient	$500 Copay per day – 4 days max	$500 Copay per admit	$250 Copay per day – 5 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$200 Copay	$150 Copay
Urgent Care	$30 Copay	$10 Copay	$15 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $150 Copay $150 Copay [8]	 $300 Copay per procedure $300 Copay per procedure	 $125 Copay per procedure $125 Copay per procedure
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$20 Copay	$30 Copay
Ambulance Services (per trip)	$100 Copay	$150 Copay	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay [12, 13] $20 Copay [12, 13] $30 Copay [12, 13] 70% (up to $250 per prescription [9]) (prior auth. required) [12, 13]	 $5 Copay $15 Copay $15 Copay (with physician approval) 90% (up to $250 per prescription [9]) (with physician approval)	 $5 Copay $15 Copay $15 Copay (with physician approval) 90% (up to $250 per prescription [9]) (with physician approval)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [12, 13]	$15 Copay	$15 Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [5]	100% [5]	100% [5]
Chronic Disease Management	$50 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	100%	90%
Chiropractic (20 visits max per year)	Not Covered	$15 Copay [10]	Not Covered
Acupuncture	$10 Copay [15]	$10 Copay [10]	$15 Copay
Physical, Occupational, Speech Therapy	$30 Copay [14]	$10 Copay	$15 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay [14]	$10 Copay	$15 Copay
Home Health Care (Max 100 visits per year)	$30 Copay	100% [1]	$20 Copay [1]

Platinum HMO

Groups Beginning 7/1/20

Services	HMO E	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$250 Copay per admit	$150 Copay per day – 5 days max
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	90% [6]	90% [6]
Mental Health In-Patient Out-Patient (office visit)	 $500 Copay per day – 4 days max [16] $30 Copay [16]	 $500 Copay per admit $10 Copay	 $250 Copay per day – 5 days max $15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $500 Copay per day – 4 days max	 $500 Copay per admit	 $250 Copay per day – 5 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [19] EyeMed 100% 100% 1 pair per calendar year None	 Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year [11] 1 pair per calendar year [11] None	 Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year [11] 1 pair per calendar year [11] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [4, 7] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [2] $365 Copay [3] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [2] $365 Copay [3] $350 Copay

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
5. See plan specific EOC for information on preventive services.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. Pediatric dental and vision are included on all plans.
8. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types
9. Maximum member responsibility.
10. 20 visits max per year combined for Chiropractic and Acupuncture.
11. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
12. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
13. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
14. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
15. Must be medically necessary.
16. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
17. 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.

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

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B
Participating Health Plans	Sharp	Sharp
Network Name	Premier	Performance
Metal Tier	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay	85%
Hospice (out-patient)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $400 Copay $15 Copay	 85% $15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $400 Copay	 85%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [5] 100% 100% $25 Copay [1] $350 Copay [2] $350 Copay	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [5] 100% 100% $25 Copay [1] $350 Copay [2] $350 Copay

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

1. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
2. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Amount listed for In-Patient Services only.

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [11]	$4,500 / $9,000 [1]	$3,500 / $7,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$10 Copay	$15 Copay [7]	$25 Copay [7]
Specialist Visit (SPC)	$20 Copay	$30 Copay	$25 Copay
Laboratory	$10 Copay	$15 Copay	$25 Copay
X-Ray	$40 Copay	$30 Copay per procedure	$25 Copay per procedure
MRI, CT and PET (office setting)	$150 Copay per procedure	$75 Copay per procedure	$150 Copay per procedure
Hospital Services – In-Patient	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit	$250 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$200 Copay	$150 Copay	$100 Copay
Urgent Care	$20 Copay	$15 Copay	$25 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 $100 Copay $100 Copay	 90% 90%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$20 Copay	$30 Copay	$25 Copay
Ambulance Services (per trip)	$200 Copay	$150 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay	 $5 Copay [2] $15 Copay [2, 3] $25 Copay [2, 3] 90% (up to $250 per prescription [8]) [2, 3]	 $5 Copay [2] $15 Copay [2, 3] $25 Copay [2, 3] 90% (up to $250 per prescription [8]) [2, 3]
Oral Contraceptives	100% (if in formulary)	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay [2, 3]	Applicable Rx Copay [2, 3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	$350 Copay per day – 5 days max [15]	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	$20 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [10]	90%	90%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay	$15 Copay	$25 Copay
Physical, Occupational, Speech Therapy	$10 Copay	$15 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$10 Copay	$15 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$10 Copay	$20 Copay	$25 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay	$150 Copay per day – 5 days max per admit	90%

Platinum HMO

Groups Beginning 7/1/20

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	90%	90%
Mental Health			
In-Patient	\$200 Copay per day – 5 days max	\$250 Copay per day – 5 days max per admit [9]	\$250 Copay per day – 5 days max per admit [9]
Out-Patient (office visit)	\$10 Copay	\$15 Copay	\$25 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	\$200 Copay per day – 5 days max	\$250 Copay per day – 5 days max per admit [9]	\$250 Copay per day – 5 days max per admit [9]
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	VSP	VSP
Network	VSP	Choice Network	Choice Network
Exam	100%	100% [5]	100% [5]
Contact Lenses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses) [5, 6]	100% (in lieu of eyeglasses) [5, 6]
Frames	100% (Pediatric Exchange collection only)	100% (in lieu of contact lenses) [5, 6]	100% (in lieu of contact lenses) [5, 6]
Maximum Allowance per year	None	1 pair per year	1 pair per year
Pediatric Dental			
Carrier	Access Dental	Delta Dental	Delta Dental
Network	Access Dental Plan Children's Dental HMO	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	\$350 / \$700 [12]	Combined with Medical	Combined with Medical
Office Visit	100%	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	\$25 Copay [13]	Copay varies by service	Copay varies by service
Major Services (no waiting period)	\$350 Copay [14]	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	\$350 Copay	\$1,000 Copay	\$1,000 Copay

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

1. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
2. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed \$250 per prescription for up to a 30-day supply. For HDHP plans, this \$250 maximum will not apply until after the deductible is met.
3. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
4. See plan specific EOC for information on preventive services.
5. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
6. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
7. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
8. Maximum member responsibility.
9. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
10. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
11. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum
12. The pediatric dental out-of-pocket maximum is \$350 for a family with one child and \$700 for a family with 2 or more children.
13. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
14. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
15. Amount listed for In-Patient Services only

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Focus	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,500 / $7,000 [2]	$3,500 / $7,000 [2]	$3,500 / $7,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$20 Copay
Specialist Visit (SPC)	$40 Copay	$40 Copay	$40 Copay
Laboratory	$25 Copay	$25 Copay	$25 Copay
X-Ray	$25 Copay	$25 Copay	$25 Copay
MRI, CT and PET (office setting)	$200 Copay per procedure	$200 Copay per procedure	$200 Copay per procedure
Hospital Services – In-Patient	80%	80%	80%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	80%	80%	80%
Urgent Care	$50 Copay	$50 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 80% 80%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$40 Copay	$40 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [5]) [3]	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [5]) [3]	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [5]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [3]	Applicable Rx Copay [3]	Applicable Rx Copay [3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [1]	100% [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [4]	$150 Copay [4]	$150 Copay [4]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$20 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$20 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$20 Copay	$20 Copay

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Focus	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%	80%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$50 Copay	$50 Copay	$50 Copay
Mental Health In-Patient Out-Patient (office visit)	 80% $20 Copay	 80% $20 Copay	 80% $20 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 80%	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 80% 80% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 80% 80% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 80% 80% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. For Specialty drugs, please see plan specific EOC.
4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Maximum member responsibility.

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$4,500 / $9,000 [1]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$15 Copay
Specialist Visit (SPC)	$25 Copay	$30 Copay
Laboratory	100%	$15 Copay
X-Ray	100%	$30 Copay
MRI, CT and PET (office setting)	$100 Copay	$75 Copay
Hospital Services – In-Patient	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	$150 Copay	$150 Copay
Urgent Care	$50 Copay	$15 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 $100 Copay $100 Copay
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$25 Copay	$40 Copay
Ambulance Services (per trip)	100%	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $30 Copay [9] $50 Copay [9] 80% (up to $250 per 30 day supply [6]) [3]	 $5 Copay $15 Copay [9] $25 Copay [9] 90% (up to $250 per 30 day supply [6]) [3]
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	$30 Copay	$15 Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [2, 5]	100% [2, 5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	90% [3]
Chiropractic (20 visits max per year)	$15 Copay [8]	$15 Copay [8]
Acupuncture	$15 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$15 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$15 Copay
Home Health Care (Max 100 visits per year)	100%	$20 Copay

Platinum HMO

Groups Beginning 7/1/20

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

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

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

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Out-of-Pocket Max Ind/Fam	$4,500 / $9,000	$2,500 / $5,000
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$15 Copay	$30 Copay
Specialist Visit (SPC)	$30 Copay	$50 Copay
Laboratory	$15 Copay	$30 Copay
X-Ray	$30 Copay [7]	$50 Copay [7]
MRI, CT and PET (office setting)	$75 Copay [7]	$50 Copay [7]
Hospital Services – In-Patient	$250 Copay per day – 5 days max per admit	$500 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	$50 Copay
Emergency Room (copay waived if admitted)	$150 Copay	$250 Copay
Urgent Care	$15 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 $150 Copay $150 Copay
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$30 Copay [4]	$50 Copay [4]
Ambulance Services (per trip)	$150 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay $15 Copay $25 Copay 90% (up to $250 per prescription [6])	 $5 Copay $15 Copay $25 Copay 70% (up to $250 per prescription [6])
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	90%	70%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	$15 Copay	$30 Copay
Physical, Occupational, Speech Therapy	$15 Copay	$30 Copay
Rehabilitative & Habilitative Services and Devices	$15 Copay [5]	$30 Copay [5]
Home Health Care (Max 100 visits per year)	$20 Copay (Max 100 visits per benefit period)	$50 Copay (Max 100 visits per benefit period)

Platinum EPO

Groups Beginning 7/1/20

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 5 days max per admit	$500 Copay per day – 5 days max per admit
Hospice (out-patient)	100%	$500 Copay
Durable Medical Equipment (Covered when medically necessary)	90% [8]	70% [8]
Mental Health		
In-Patient	$250 Copay per day – 5 days max per admit	$500 Copay per day – 5 days max per admit
Out-Patient (office visit)	$15 Copay	$30 Copay
Drug/Substance Abuse		
In-Patient (Detox Only)	$250 Copay per day – 5 days max per admit	$500 Copay per day – 5 days max per admit
Infertility		
Infertility Evaluation and Treatment	Covered for Evaluation Only [3]	Covered for Evaluation Only [3]
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	Oscar	Oscar
Network	Davis Vison	Davis Vision
Exam	100% [2, 9]	$50 Copay [2, 9]
Contact Lenses	100% (only in lieu of eyeglasses)	70% (only in lieu of eyeglasses)
Frames	100%	70%
Maximum Allowance per year	1 pair per calendar year	1 pair per calendar year
Pediatric Dental		
Carrier	Oscar	Oscar
Network	Liberty	Liberty
Deductible	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100% [2]	100% [2]
Basic Services	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service (prior auth. required)	Copay Varies by service (prior auth. required)
Orthodontics (medically necessary)	$1,000 Copay (prior auth. required)	100% (prior auth. required)

* *All services are subject to the deductible unless otherwise stated.
1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
4. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
5. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
6. Maximum member responsibility.
7. Prior-Authorization may be required.
8. Prior-Authorization required if annual cost is greater than $500.
9. Limit one exam per 12 months.

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible *	None	None	None
Out-of-Pocket Max Ind/Fam	$5,800 / $11,600 [4]	$5,800 / $11,600 [4]	$7,000 / $14,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$30 Copay	$30 Copay
Specialist Visit (SPC)	$55 Copay	$55 Copay	$45 Copay
Laboratory	$25 Copay [7]	$25 Copay [7]	$40 Copay
X-Ray	$40 Copay [7]	$40 Copay [7]	$50 Copay
MRI, CT and PET (office setting)	$100 Copay per test [12]	$100 Copay per test [12]	$250 Copay per procedure
Hospital Services – In-Patient	$500 Copay per day – 4 days max per admit	$500 Copay per day – 4 days max per admit	$500 Copay per day – 3 days max
In-Patient Physician Fees	100%	100%	60%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$250 Copay
Urgent Care	$30 Copay	$30 Copay	$45 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $500 Copay	 $500 Copay $500 Copay	 60% 60% [13]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$55 Copay	$45 Copay
Ambulance Services (per trip)	$150 Copay [1]	$150 Copay [1]	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [2] $40 Copay [2] $80 Copay [2] 70% (up to $250 per prescription [10]) (prior auth. required) [2, 8]	 $15 Copay [2] $40 Copay [2] $80 Copay [2] 70% (up to $250 per prescription [10]) (prior auth. required) [2, 8]	 $10 Copay [14, 15] $50 Copay [14, 15] $60 Copay [14, 15] 60% (up to $250 per prescription [10]) (prior auth. required) [14, 15]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [2]	Applicable Rx Copay [2]	Applicable Rx Copay [14, 15]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3]	100% [3]	100% [3]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	$45 Copay
Chemotherapy	$55 Copay	$55 Copay	100%
Chiropractic (20 visits max per year)	$30 Copay (20 visits max per benefit period) [6]	$30 Copay (20 visits max per benefit period) [6]	Not Covered
Acupuncture	$30 Copay	$30 Copay	$10 Copay [16]
Physical, Occupational, Speech Therapy	$30 Copay [7]	$30 Copay [7]	$30 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay [7]	$30 Copay [7]	$30 Copay
Home Health Care (Max 100 visits per year)	$55 Copay (Max 100 visits per benefit period) [5]	$55 Copay (Max 100 visits per benefit period) [5]	$30 Copay

Gold HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 4 days max per admit [11]	$150 Copay per day – 4 days max per admit [11]	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$100 Copay	$100 Copay	60%
Mental Health			
In-Patient	$500 Copay per day – 4 days max per admit	$500 Copay per day – 4 days max per admit	$500 Copay per day – 3 days max [17]
Out-Patient (office visit)	$30 Copay	$30 Copay	$30 Copay [17]
Drug/Substance Abuse			
In-Patient (Detox Only)	$500 Copay per day – 4 days max per admit	$500 Copay per day – 4 days max per admit	$500 Copay per day – 3 days max
Infertility			
Infertility Evaluation and Treatment	$30 Copay [9]	$30 Copay [9]	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	Anthem Vision	EyeMed [18]
Network	Blue View Vision	Blue View Vision	EyeMed
Exam	100%	100%	100%
Contact Lenses	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	100%
Frames	100%	100%	1 pair per calendar year
Maximum Allowance per year	1 per calendar year	1 per calendar year	None
Pediatric Dental			
Carrier	Anthem Dental	Anthem Dental	Dental Benefit Providers [18, 19]
Network	Prime	Prime	Dental Benefit Providers
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	50%	50%	Copay varies by service
Major Services (no waiting period)	50%	50%	Copay varies by service
Orthodontics (medically necessary)	50%	50%	Copay varies by service

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

1. Medical emergency only.
2. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
5. Limited to 100 4-hour visits per benefit period.
6. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
9. Evaluation only.
10. Maximum member responsibility.
11. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
12. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
13. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
14. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
15. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
16. Must be medically necessary.
17. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
18. Pediatric dental and vision are included on all plans.
19. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.

Services	HMO B	HMO C	HMO D
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	Salud HMO y Mas
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000	$6,000 / $12,000	$6,000 / $12,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay	$35 Copay	$35 Copay
Specialist Visit (SPC)	$60 Copay	$55 Copay	$55 Copay
Laboratory	$40 Copay	$40 Copay	$40 Copay
X-Ray	$50 Copay	$50 Copay	$50 Copay
MRI, CT and PET (office setting)	$300 Copay per procedure	$300 Copay per procedure	$300 Copay per procedure
Hospital Services – In-Patient	$1,000 Copay	$750 Copay per day – 3 days max	$750 Copay per day – 3 days max
In-Patient Physician Fees	60%	100%	100%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$300 Copay
Urgent Care	$60 Copay	$55 Copay	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60% [11]	 $1,200 Copay $480 Copay [11]	 $1,200 Copay $480 Copay [11]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay	$55 Copay	$55 Copay
Ambulance Services (per trip)	$300 Copay	$300 Copay	$300 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 60% (up to $250 per prescription [10]) (prior auth. required) [5, 7]	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 70% (up to $250 per prescription [10]) (prior auth. required) [5, 7]	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 70% (up to $250 per prescription [10]) (prior auth. required) [5, 7]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [5, 7]	Applicable Rx Copay [5, 7]	Applicable Rx Copay [5, 7]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3]	100% [3]	100% [3]
Chronic Disease Management	$60 Copay	$55 Copay	$55 Copay
Chemotherapy	100%	100%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay [1]	$10 Copay [1]	$10 Copay [1]
Physical, Occupational, Speech Therapy	$45 Copay	$35 Copay [6]	$35 Copay [6]
Rehabilitative & Habilitative Services and Devices	$45 Copay	$35 Copay [6]	$35 Copay [6]
Home Health Care (Max 100 visits per year)	$45 Copay	$35 Copay	$35 Copay

Gold HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C	HMO D
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	Salud HMO y Mas
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	60%	70%	70%
Mental Health In-Patient Out-Patient (office visit)	 $1,000 Copay [4] $45 Copay [4]	 $750 Copay per day – 3 days max [4] $35 Copay [4]	 $750 Copay per day – 3 days max [4] $35 Copay [4]
Drug/Substance Abuse In-Patient (Detox Only)	 $1,000 Copay	 $750 Copay per day – 3 days max	 $750 Copay per day – 3 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. Must be medically necessary.
2. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
3. See plan specific EOC for information on preventive services.
4. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
5. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
6. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Pediatric dental and vision are included on all plans.
10. Maximum member responsibility.
11. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.

Services	HMO E	HMO F	HMO A
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$500 / $1,000 [6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000	$7,000 / $14,000	$7,000 / $14,000 [7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$45 Copay	$30 Copay (ded waived)
Specialist Visit (SPC)	$55 Copay	$60 Copay	$35 Copay (ded waived)
Laboratory	$40 Copay	$40 Copay	$20 Copay (ded waived)
X-Ray	$50 Copay	$50 Copay	$40 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay per procedure	$300 Copay per procedure	$300 Copay per procedure
Hospital Services – In-Patient	$750 Copay per day – 3 days max	$1,000 Copay	$600 Copay per day – 5 days max
In-Patient Physician Fees	100%	60%	100%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$250 Copay
Urgent Care	$55 Copay	$60 Copay	$30 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $1,200 Copay $480 Copay [9]	 60% 60% [9]	 $600 Copay per procedure $600 Copay per procedure
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$60 Copay	$35 Copay (ded waived)
Ambulance Services (per trip)	$300 Copay	$300 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [14, 16] $50 Copay [14, 16] $70 Copay [14, 16] 70% (up to $250 per prescription [11]) (prior auth. required) [14, 16]	 $15 Copay [14, 16] $50 Copay [14, 16] $70 Copay [14, 16] 60% (up to $250 per prescription [11]) (prior auth. required) [14, 16]	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) $50 Copay (overall ded waived) (with physician approval) 80% (up to $250 per prescription [11]) (overall ded waived) (with physician approval)
Oral Contraceptives	100%	100%	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay [14, 16]	Applicable Rx Copay [14, 16]	$50 Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [5]	100% [5]	100% (ded waived) [5]
Chronic Disease Management	$55 Copay	$60 Copay	Covered as any Illness
Chemotherapy	100%	100%	100% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	$15 Copay (ded waived) [12]
Acupuncture	$10 Copay [4]	$10 Copay [4]	$30 Copay (ded waived) [12]
Physical, Occupational, Speech Therapy	$35 Copay [15]	$45 Copay [15]	$30 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$35 Copay [15]	$45 Copay [15]	$30 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$35 Copay	$45 Copay	100% (ded waived) [1]

Gold HMO

Groups Beginning 7/1/20

Services	**HMO E**	**HMO F**	**HMO A**
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$300 Copay per day – 5 days max
Hospice (out-patient)	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	70%	60%	80% (ded waived) [8]
Mental Health In-Patient Out-Patient (office visit)	 $750 Copay per day – 3 days max [10] $35 Copay [10]	 $1,000 Copay [10] $45 Copay [10]	 $600 Copay per day – 5 days max $30 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 $750 Copay per day – 3 days max	 $1,000 Copay	 $600 Copay per day – 5 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [18] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [18] EyeMed 100% 100% 1 pair per calendar year None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [13] 1 pair per calendar year (ded waived) [13] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [17, 18] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [17, 18] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $40 Copay [2] $365 Copay [3] $350 Copay

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. Must be medically necessary.
5. See plan specific EOC for information on preventive services.
6. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
7. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
8. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
9. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
10. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
11. Maximum member responsibility.
12. 20 visits max per year combined for Chiropractic and Acupuncture.
13. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
14. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
15. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
16. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
17. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
18. Pediatric dental and vision are included on all plans.

Services	HMO B	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Performance	Premier
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$250 / $500 [12] (applies to Max OOP)	None	None
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [9]	$8,000 / $16,000 [3]	$8,000 / $16,000 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay (ded waived)	$20 Copay	$25 Copay
Specialist Visit (SPC)	$50 Copay (ded waived)	$50 Copay	$55 Copay
Laboratory	$25 Copay (ded waived)	$15 Copay	$15 Copay
X-Ray	$65 Copay (ded waived)	$20 Copay	$55 Copay
MRI, CT and PET (office setting)	$275 Copay per procedure (ded waived)	$175 Copay per procedure	$175 Copay per procedure
Hospital Services – In-Patient	$600 Copay per day – 5 days max	70%	$600 Copay per day – 5 days max
In-Patient Physician Fees	100% (ded waived)	70%	100%
Emergency Room (copay waived if admitted)	$250 Copay	70%	$300 Copay
Urgent Care	$25 Copay (ded waived)	$50 Copay	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $340 Copay per procedure (ded waived) $340 Copay per procedure (ded waived)	 70% 70%	 75% 75%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay (ded waived)	$50 Copay	$55 Copay
Ambulance Services (per trip)	$250 Copay	70%	$200 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) $50 Copay (overall ded waived) (with physician approval) 80% (up to $250 per prescription [11])(overall ded waived) (with physician approval)	 $19 Copay (ded waived) $150 / $300 Ded – $35 Copay $150 / $300 Ded – $70 Copay $150 / $300 Ded – Applicable Rx Copay	 $19 Copay (ded waived) $300 / $600 Ded – $40 Copay $300 / $600 Ded – $75 Copay $300 / $600 Ded – Applicable Rx Copay
Oral Contraceptives	100% (ded waived)	100% (if in formulary)	100% (if in formulary)
Diabetes – Self-Injectable	$50 Copay (overall ded waived)	$150 / $300 Ded – Applicable Rx Copay	$300 / $600 Ded – Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	70% [10]	$600 Copay per day – 5 days max [10]
Preventive/Wellness Services	100% (ded waived) [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	$50 Copay	$55 Copay
Chemotherapy	80% (ded waived)	Variable [6]	Variable [6]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$25 Copay (ded waived)	$20 Copay	$25 Copay
Physical, Occupational, Speech Therapy	$25 Copay (ded waived)	$20 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay (ded waived)	$20 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$30 Copay (ded waived) [7]	$20 Copay	$25 Copay

Gold HMO

Groups Beginning 7/1/20

Services	HMO B	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Performance	Premier
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max	70%	$25 Copay per day
Hospice (out-patient)	100% (ded waived)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) [8]	50%	50%
Mental Health			
In-Patient	$600 Copay per day – 5 days max	70%	$200 Copay per day – 5 days max
Out-Patient (office visit)	$25 Copay (ded waived)	$20 Copay	$25 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day – 5 days max	70%	$200 Copay per day – 5 days max
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Kaiser Permanente	VSP	VSP
Network	Kaiser Permanente	VSP	VSP
Exam	100% (ded waived)	100%	100%
Contact Lenses	1 pair per calendar year [13]	1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses
Frames	1 pair per calendar year (ded waived) [13]	100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Access Dental	Access Dental
Network	DeltaCare USA	Access Dental Plan Children's Dental HMO	Access Dental Plan Children's Dental HMO
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700 [5]	$350 / $700 [5]
Office Visit	100% (ded waived)	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100%	100%
Basic Services	$40 Copay [1]	$25 Copay [1]	$25 Copay [1]
Major Services (no waiting period)	$365 Copay [2]	$350 Copay [2]	$350 Copay [2]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$350 Copay

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

1. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
2. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
8. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
9. 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..
10. Amount listed for In-Patient Services only.
11. Maximum member responsibility.
12. 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.
13. 1 pair of glasses or 1 pair of contact lenses per accumulation period.

Services	HMO D	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$1,500 / $3,000 [14] (applies to Max OOP)	$250 / $500 [14] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500/ $13,000 [4]	$3,000 / $6,000 [6]	$7,800 / $15,600 [6]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$30 Copay [7]	$25 Copay (ded waived) [7]
Specialist Visit (SPC)	$55 Copay	$50 Copay	$50 Copay (ded waived)
Laboratory	$15 Copay	$30 Copay	$25 Copay (ded waived)
X-Ray	$55 Copay	$30 Copay per procedure	$65 Copay per procedure (ded waived)
MRI, CT and PET (office setting)	$175 Copay per procedure	$50 Copay per procedure	$275 Copay per procedure (ded waived)
Hospital Services – In-Patient	$1,500 Copay	80%	$600 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	80%	100% (ded waived)
Emergency Room (copay waived if admitted)	$300 Copay	$150 Copay	$250 Copay
Urgent Care	$55 Copay	$30 Copay	$25 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $600 Copay per procedure $600 Copay per procedure	 80% 80%	 $300 Copay (ded waived) $300 Copay (ded waived)
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$50 Copay	$50 Copay (ded waived)
Ambulance Services (per trip)	$200 Copay	$150 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $19 Copay $35 Copay $70 Copay Applicable Rx Copay	 $5 Copay (overall ded waived) [8] $15 Copay (overall ded waived) [8, 9] $25 Copay (overall ded waived) [8, 9] 80% (up to $250 per prescription [5]) (overall ded waived) [8, 9]	 $15 Copay (overall ded waived) [8] $50 Copay (overall ded waived) [8, 9] $80 Copay (overall ded waived) [8, 9] 80% (up to $250 per prescription [5]) (overall ded waived) [8, 9]
Oral Contraceptives	100% (if in formulary)	100% (overall ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay (overall ded waived) [8, 9]	Applicable Rx Copay (overall ded waived) [8, 9]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	$1,500 Copay [16]	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	$55 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [15]	80%	80% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$35 Copay	$30 Copay	$25 Copay (ded waived)
Physical, Occupational, Speech Therapy	$35 Copay	$30 Copay	$25 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$35 Copay	$30 Copay	$25 Copay (ded waived)

Gold HMO

Groups Beginning 7/1/20

Services	HMO D	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	$35 Copay	80%	$30 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$175 Copay	80%	$300 Copay per day – 5 days max per admit
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	80%	80% (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 $1,000 Copay $35 Copay	 80% [12] $30 Copay	 $600 Copay per day – 5 days max per admit [12] $25 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 $1,000 Copay	 80% [12]	 $600 Copay per day – 5 days max per admit [12]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [10] 100% (in lieu of eyeglasses) (ded waived) [10, 11] 100% (in lieu of contact lenses) (ded waived) [10, 11] 1 pair per year	 VSP Choice Network 100% (ded waived) [10] 100% (in lieu of eyeglasses) (ded waived) [10, 11] 100% (in lieu of contact lenses) (ded waived) [10, 11] 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [13] 100% 100% $25 Copay [2] $350 Copay [3] $350 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)

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

1. See plan specific EOC for information on preventive services.
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
5. Maximum member responsibility.
6. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
7. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
8. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
9. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
10. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
11. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.

(Footnotes continued on page 93)

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Focus
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,250 / $2,500 [6] (applies to Max OOP)	$1,250 / $2,500 [6] (applies to Max OOP)	$1,250 / $2,500 [6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [2]	$6,500 / $13,000 [2]	$6,500 / $13,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
Specialist Visit (SPC)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)
Laboratory	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
X-Ray	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
MRI, CT and PET (office setting)	$200 Copay per procedure (ded waived)	$200 Copay per procedure (ded waived)	$200 Copay per procedure (ded waived)
Hospital Services – In-Patient	70%	70%	70%
In-Patient Physician Fees	70% (ded waived)	70% (ded waived)	70% (ded waived)
Emergency Room (copay waived if admitted)	70%	70%	70%
Urgent Care	$75 Copay (ded waived)	$75 Copay (ded waived)	$75 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 70% 70%	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) $250 / $500 Ded – $40 Copay [3] $250 / $500 Ded – $80 Copay [3] $250 / $500 Ded – 75% (up to $250 per prescription [5]) [3]	 $15 Copay (ded waived) $250 / $500 Ded – $40 Copay [3] $250 / $500 Ded – $80 Copay [3] $250 / $500 Ded – 75% (up to $250 per prescription [5]) [3]	 $15 Copay (ded waived) $250 / $500 Ded – $40 Copay [3] $250 / $500 Ded – $80 Copay [3] $250 / $500 Ded – 75% (up to $250 per prescription [5]) [3]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [3]	Applicable Ded / Rx Copay [3]	Applicable Ded / Rx Copay [3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay (ded waived) [4]	$150 Copay (ded waived) [4]	$150 Copay (ded waived) [4]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Acupuncture	$10 Copay (ded waived)	$10 Copay (ded waived)	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)

Gold HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Focus
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	70%	70%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$50 Copay (ded waived)	$50 Copay (ded waived)	$50 Copay (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 70% $30 Copay (ded waived)	 70% $30 Copay (ded waived)	 70% $30 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 70%	 70%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. For Specialty drugs, please see plan specific EOC.
4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Maximum member responsibility.
6. 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.

Services	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$250 / $500 [1, 7] (applies to Max OOP)	$1,000 / $2,000 [1, 7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [2]	$7,800 / $15,600 [2, 7]	$6,750 / $13,500 [2, 7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay	$25 Copay (ded waived)	$40 Copay (ded waived)
Specialist Visit (SPC)	$40 Copay	$50 Copay (ded waived)	$40 Copay (ded waived)
Laboratory	$40 Copay	$25 Copay (ded waived)	100% (ded waived)
X-Ray	$40 Copay	$65 Copay (ded waived)	100% (ded waived)
MRI, CT and PET (office setting)	$300 Copay	$275 Copay (ded waived)	$300 Copay (ded waived)
Hospital Services – In-Patient	$600 Copay per day	$600 Copay per day [1] – Days 1-5	$500 Copay per day [1] – Days 1-5
In-Patient Physician Fees	100%	100% (ded waived)	100% (ded waived)
Emergency Room (copay waived if admitted)	$300 Copay	$250 Copay	$300 Copay [1]
Urgent Care	$100 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay $300 Copay	 $300 Copay (ded waived) $300 Copay (ded waived)	 $500 Copay [1] $500 Copay [1]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$55 Copay (ded waived)	$40 Copay (ded waived)
Ambulance Services (per trip)	100%	$250 Copay [1]	100% (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay $50 Copay [12] $75 Copay [12] 80% (up to $250 per 30 day supply [9]) [10]	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) [12] $80 Copay (overall ded waived) [12] 80% (up to $250 per 30 day supply [9]) (overall ded waived) [10]	 $10 Copay (ded waived) $250 / $500 Ded – $50 Copay [1, 12] $250 / $500 Ded – $75 Copay [1, 12] $250 / $500 Ded – 80% (up to $250 per 30 day supply [9]) [1, 10]
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$50 Copay	$50 Copay (overall ded waived)	$250 / $500 Ded – $50 Copay [1]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3, 5]	100% (ded waived) [3, 5]	100% (ded waived) [3,5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	80% (ded waived) [10]	100% (ded waived)
Chiropractic (20 visits max per year)	$15 Copay [8]	$15 Copay (ded waived) [8]	$15 Copay (ded waived) [8]
Acupuncture	$15 Copay	$15 Copay (ded waived)	$15 Copay (ded waived)
Physical, Occupational, Speech Therapy	$40 Copay	$25 Copay (ded waived)	$40 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$40 Copay	$25 Copay (ded waived)	$40 Copay (ded waived)
Home Health Care (Max 100 visits per year)	100%	$30 Copay (ded waived)	100% (ded waived)

Gold HMO

Groups Beginning 7/1/20

Services	**HMO A**	**HMO B**	**HMO C**
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$600 Copay per day	$300 Copay per day [1] – Days 1-5	$500 Copay per day [1] – Days 1-5
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80% [4, 10]	80% (ded waived) [4, 10]	80% (ded waived) [4, 10]
Mental Health			
In-Patient	$600 Copay per day	$600 Copay per day [1] – Days 1-5	$500 Copay per day [1] – Days 1-5
Out-Patient (office visit)	$40 Copay	$25 Copay (ded waived)	$40 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day	$600 Copay per day [1] – Days 1-5	$500 Copay per day [1] – Days 1-5
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	MES Vision	MES Vision	MES Vision
Network	Eyewear Only	Eyewear Only	Eyewear Only
Exam	100%	100% (ded waived)	100% (ded waived)
Contact Lenses	100%	100% (ded waived)	100% (ded waived)
Frames	100%	100% (ded waived)	100% (ded waived)
Maximum Allowance per year	1 per calendar year [6]	1 per calendar year [6]	1 per calendar year [6]
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay	$1,000 Copay

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

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

Services	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Gold**
Calendar Year Deductible*	$2,000 / $2,800 / $4,000 [1, 9] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [2]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	100% [1]
Specialist Visit (SPC)	100% [1]
Laboratory	100% [1]
X-Ray	100% [1]
MRI, CT and PET (office setting)	100% [1]
Hospital Services – In-Patient	100% [1]
In-Patient Physician Fees	100% [1]
Emergency Room (copay waived if admitted)	100% [1]
Urgent Care	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% [1] 100% [1]
Hospital Pre-Authorization	Required
2nd Surgical Opinion	100% [1]
Ambulance Services (per trip)	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% [1] (combined Med/Rx ded) $30 Copay (combined Med/Rx ded) [1, 10] $50 Copay (combined Med/Rx ded) [1, 10] 80% (up to $250 per 30 day supply [7]) (combined Med/Rx ded) [1, 8]
Oral Contraceptives	100% (ded waived)
Diabetes – Self-Injectable	$30 Copay (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3,5]
Chronic Disease Management	Covered as any Illness
Chemotherapy	100% [1]
Chiropractic (20 visits max per year)	100% [1]
Acupuncture	100% [1]
Physical, Occupational, Speech Therapy	100% [1]
Rehabilitative & Habilitative Services and Devices	100% [1]
Home Health Care (Max 100 visits per year)	100% [1]

Gold HMO

Groups Beginning 7/1/20

Services	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100% [1]
Hospice (out-patient)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	100% [1,4]
Mental Health In-Patient Out-Patient (office visit)	 100% [1] 100% [1]
Drug/Substance Abuse In-Patient (Detox Only)	 100% [1]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [6]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. Limited to one pair of glasses with standard lenses or one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.
7. Maximum member responsibility.
8. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
9. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
10. Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier1 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.

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $3,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,250 / $12,500 [1]	$12,500 / $25,000 [1]	$6,000 / $12,000 [1]	$12,000 / $24,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
Specialist Visit (SPC)	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Laboratory	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
X-Ray	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
MRI, CT and PET (office setting)	80% [14]	50% (up to $800 per test) [5]	75% [14]	50% (up to $800 per test) [5]
Hospital Services – In-Patient	Tier 1: 80% Tier 2: $500 Copay per admit – 80%	50% (up to $650 per day) [5]	75%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	75%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%		$250 Copay – 75%	
Urgent Care	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	Tier 1: 80% Tier 2: $250 Copay per admit – 80% Tier 1: 80% Tier 2: $250 Copay per admit – 80%	50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	75% 75%	50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [13]		75% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	$15 Copay (ded waived) [2] $200 / $400 Ded – $40 Copay [2] $200 / $400 Ded – $80 Copay [2] $200 / $400 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	Not Covered Not Covered Not Covered Not Covered	$15 Copay (ded waived) [2] $250 / $500 Ded – $40 Copay [2] $250 / $500 Ded – $80 Copay [2] $250 / $500 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	80%	50% [14]	75%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered

Gold PPO

Groups Beginning 7/1/20

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Acupuncture	$30 Copay (ded waived)	Not Covered	$25 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	50% [14]	$25 Copay (ded waived)	50% [14]
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived) [11]	50% [11]	$25 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	75% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 80% [12] Tier 2: $500 Copay per admit – 80% [12]	50% (up to $150 per day) [5, 12]	75% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health In-Patient Out-Patient (office visit)	 Tier 1: 80% Tier 2: $500 Copay per admit – 80% $30 Copay (ded waived)	 50% (up to $650 per day) [5] 50%	 75% $25 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 Tier 1: 80% Tier 2: $500 Copay per admit – 80%	 50% (up to $650 per day) [5]	 75%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $30 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $25 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

(Footnotes continued on page 93)

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,200 / $2,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,400 / $4,800 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,100 / $10,200 [1]	$10,200 / $20,400 [1]	$5,500 / $11,000 [1]	$11,000 / $22,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
Specialist Visit (SPC)	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Laboratory	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
X-Ray	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
MRI, CT and PET (office setting)	80% [14]	50% (up to $800 per test) [5]	75% [14]	50% (up to $800 per test) [5]
Hospital Services – In-Patient	80%	50% (up to $650 per day) [5]	75%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	75%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%		$250 Copay – 75%	
Urgent Care	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit – 80% $250 Copay per admit – 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 75% 75%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [13]		75% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) [2] $200 / $400 Ded – $40 Copay [2] $200 / $400 Ded – $80 Copay [2] $200 / $400 Ded – 70% (up to $250 per prescription [8]) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 $15 Copay (ded waived) [2] $300 / $600 Ded – $40 Copay [2] $300 / $600 Ded – $80 Copay [2] $300 / $600 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	80%	50% [14]	75%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$30 Copay (ded waived)	Not Covered	$25 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	50% [14]	$25 Copay (ded waived)	50% [14]

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived) [11]	50% [11]	$25 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	75% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% [12]	50% (up to $150 per day) [5, 12]	75% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health In-Patient Out-Patient (office visit)	 80% $30 Copay (ded waived)	 50% (up to $650 per day) [5] 50%	 75% $25 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 50% (up to $650 per day) [5]	 75%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $30 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $25 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic &Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

(Footnotes continued on page 93)

Services	PPO E	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Gold**	
	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,100 / $10,200 [1]	$10,200 / $20,400 [1]
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%
Specialist Visit (SPC)	$60 Copay (ded waived)	50%
Laboratory	$30 Copay (ded waived)	50%
X-Ray	$60 Copay (ded waived)	50%
MRI, CT and PET (office setting)	80% [14]	50% (up to $800 per test) [5]
Hospital Services –In-Patient	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%	
Urgent Care	$60 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit – 80% $250 Copay per admit – 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required	
2nd Surgical Opinion	$60 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) [2] $200 / $400 Ded – $40 Copay [2] $200 / $400 Ded – $80 Copay [2] $200 / $400 Ded – 70% (up to $250 per prescription [8]) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness	
Chemotherapy	80%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$30 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	50% [14]

Gold PPO

Groups Beginning 7/1/20

Services	**PPO E**	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	
Metal Tier	**Gold**	
	In-Network	Out-of-Network [9]
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	
Mental Health In-Patient Out-Patient (office visit)	 80% $30 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $30 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

* All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 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.

(Footnotes continued on page 93)

Services	EPO A	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$250 / $500 (combined Med/ Pediatric dental ded)(applies to Max OOP)	$2,000 / $4,000 (combined Med/ Rx/Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000	$7,800 / $15,600	$7,500 / $15,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$25 Copay (ded waived)	$25 Copay (ded waived)
Specialist Visit (SPC)	$50 Copay	$50 Copay (ded waived)	$50 Copay (ded waived)
Laboratory	$50 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
X-Ray	$50 Copay [7]	$65 Copay (ded waived) [7]	$50 Copay (ded waived) [7]
MRI, CT and PET (office setting)	$200 Copay [7]	$275 Copay (ded waived) [7]	80% [7]
Hospital Services – In-Patient	70%	$600 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	70%	100% (ded waived)	80%
Emergency Room (copay waived if admitted)	$350 Copay	$250 Copay	$500 Copay (ded waived)
Urgent Care	$50 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 $300 Copay (ded waived) $300 Copay (ded waived)	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay [5]	$50 Copay (ded waived) [5]	$50 Copay (ded waived) [5]
Ambulance Services (per trip)	$350 Copay	$250 Copay	$500 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay $50 Copay $75 Copay 70% (up to $250 per prescription [3])	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) $80 Copay (overall ded waived) 80% (up to $250 per prescription [3]) (overall ded waived)	 $10 Copay (ded waived) $50 Copay (ded waived) $75 Copay (ded waived) 80% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay (overall ded waived)	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	70%	80% (ded waived)	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$30 Copay	$25 Copay (ded waived)	$25 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay [6]	$25 Copay (ded waived) [6]	$50 Copay (ded waived) [6]
Home Health Care (Max 100 visits per year)	$50 Copay (Max 100 visits per benefit period)	$30 Copay (ded waived)(Max 100 visits per benefit period)	$50 Copay (ded waived)(Max 100 visits per benefit period)

Gold EPO

Groups Beginning 7/1/20

Services	EPO A	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	$300 Copay per day – 5 days max per admit	80%
Hospice (out-patient)	70%	100% (ded waived)	80%
Durable Medical Equipment (Covered when medically necessary)	70% [8]	80% (ded waived) [8]	80% [8]
Mental Health			
In-Patient	70%	$600 Copay per day – 5 days max per admit	80%
Out-Patient (office visit)	$30 Copay	$25 Copay (ded waived)	$25 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	70%	$600 Copay per day – 5 days max per admit	80%
Infertility			
Infertility Evaluation and Treatment	Covered for Evaluation Only [4]	Covered for Evaluation Only [4]	Covered for Evaluation Only [4]
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Oscar	Oscar	Oscar
Network	Davis Vision	Davis Vision	Davis Vision
Exam	$50 Copay [2, 9]	100% (ded waived) [2, 9]	$50 Copay (ded waived) [2, 9]
Contact Lenses	70% (only in lieu of eyeglasses)	100% (ded waived) (only in lieu of eyeglasses)	80% (only in lieu of eyeglasses)
Frames	70%	100% (ded waived)	80%
Maximum Allowance per year	1 pair per calendar year	1 pair per calendar year	1 pair per calendar year
Pediatric Dental			
Carrier	Oscar	Oscar	Oscar
Network	Liberty	Liberty	Liberty
Deductible	None	Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100% [2]	100% (ded waived) [2]	100% (ded waived) [2]
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service (prior auth. required)	Copay varies by service (prior auth. required)	Copay varies by service (prior auth. required)
Orthodontics (medically necessary)	$1,000 Copay (prior auth. required)	$1,000 Copay (prior auth. required)	80% (prior auth. required)

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

1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Maximum member responsibility.
4. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
5. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
6. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
7. Prior-Authorization may be required.
8. Prior-Authorization required if annual cost is greater than $500.
9. Limit one exam per 12 months.

Services	EPO D
Participating Health Plans	Oscar
Network Name	Oscar EPO
Metal Tier	**Gold**
Calendar Year Deductible*	$1,000 / $2,000 (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	$25 Copay (ded waived)
Specialist Visit (SPC)	$50 Copay (ded waived)
Laboratory	$50 Copay (ded waived)
X-Ray	$50 Copay (ded waived) [6]
MRI, CT and PET (office setting)	80% [6]
Hospital Services – In-Patient	80%
In-Patient Physician Fees	80%
Emergency Room (copay waived if admitted)	$500 Copay (ded waived)
Urgent Care	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%
Hospital Pre-Authorization	Required
2nd Surgical Opinion	$50 Copay (ded waived) [4]
Ambulance Services (per trip)	$500 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) $50 Copay (ded waived) $75 Copay (ded waived) 80% (up to $250 per prescription [9]) (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness
Chemotherapy	80%
Chiropractic (20 visits max per year)	Not Covered
Acupuncture	$25 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [5]
Home Health Care (Max 100 visits per year)	$50 Copay (ded waived)(Max 100 visits per benefit period)

Gold EPO

Groups Beginning 7/1/20

Services	EPO D
Participating Health Plans	Oscar
Network Name	Oscar EPO
Metal Tier	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%
Hospice (out-patient)	80%
Durable Medical Equipment (Covered when medically necessary)	80% [7]
Mental Health In-Patient Out-Patient (office visit)	 80% $25 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Covered for Evaluation Only [3] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision $50 Copay (ded waived) [2, 8] 80% (only in lieu of eyeglasses) 80% 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service (prior auth. required) 80% (prior auth. required)

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

1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
4. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
5. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
6. Prior-Authorization may be required.
7. Prior-Authorization required if annual cost is greater than $500.
8. Limit one exam per 12 months.
9. Maximum member responsibility.

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,200 / $4,400 [2] (combined Med/ Pediatric dental ded) (applies to Max OOP)	$2,200 / $4,400 [2] (combined Med/ Pediatric dental ded) (applies to Max OOP)	None
Out-of-Pocket Max Ind/Fam	$8,150 / $16,300 [3]	$8,150 / $16,300 [3]	$7,800 / $15,600
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay
Specialist Visit (SPC)	$110 Copay (ded waived)	$110 Copay (ded waived)	$70 Copay
Laboratory	$55 Copay (ded waived) [12]	$55 Copay (ded waived) [12]	$40 Copay
X-Ray	$90 Copay (ded waived) [12]	$90 Copay (ded waived) [12]	$50 Copay
MRI, CT and PET (office setting)	$150 Copay per test (ded waived) [14]	$150 Copay per test (ded waived) [14]	$300 Copay per procedure
Hospital Services – In-Patient	55%	55%	50%
In-Patient Physician Fees	100% (ded waived)	100% (ded waived)	50%
Emergency Room (copay waived if admitted)	$350 Copay – 55%	$350 Copay – 55%	50%
Urgent Care	$60 Copay (ded waived)	$60 Copay (ded waived)	$70 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 55% 55%	 55% 55%	 50% 60% [17]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$110 Copay (ded waived)	$110 Copay (ded waived)	$70 Copay
Ambulance Services (per trip)	55% [8]	55% [8]	50%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [9] $300 / $600 Ded – $80 Copay [9] $300 / $600 Ded – $110 Copay [9] $300 / $600 Ded – 70% (up to $250 per prescription [7])(prior auth. required) [5, 9]	 $20 Copay (ded waived) [9] $300 / $600 Ded - $80 Copay [9] $300 / $600 Ded - $110 Copay [9] $300 / $600 Ded – 70% (up to $250 per prescription [7])(prior auth. required) [5, 9]	 $20 Copay (ded waived) [15, 16] $500 / $1,000 Ded – 50% (up to $250 per prescription [7]) [15, 16] $500 / $1,000 Ded – 50% (up to $250 per prescription [7]) [15, 16] $500 / $1,000 Ded – 50% (up to $250 per prescription [7]) (prior auth. required) [15, 16]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [9]	Applicable Ded / Rx Copay [9]	$500 / $1,000 Ded – Applicable Rx Copay [15, 16]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	$70 Copay
Chemotherapy	55% (ded waived) [10]	55% (ded waived) [10]	100%
Chiropractic (20 visits max per year)	$35 Copay (ded waived) (20 visits max per benefit period) [11]	$35 Copay (ded waived) (20 visits max per benefit period) [11]	Not Covered
Acupuncture	$60 Copay (ded waived)	$60 Copay (ded waived)	$10 Copay
Physical, Occupational, Speech Therapy	$60 Copay (ded waived) [12]	$60 Copay (ded waived) [12]	$50 Copay
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived) [12]	$60 Copay (ded waived) [12]	$50 Copay

Silver HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	$110 Copay (ded waived) (Max 100 visits per benefit period) [4]	$110 Copay (ded waived) (Max 100 visits per benefit period) [4]	$50 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	55% [13]	55% [13]	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health			
In-Patient	55%	55%	50% [20]
Out-Patient (office visit)	$60 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay [20]
Drug/Substance Abuse			
In-Patient (Detox Only)	55%	55%	50%
Infertility			
Infertility Evaluation and Treatment	$60 Copay (ded waived) [6]	$60 Copay (ded waived) [6]	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	Anthem Vision	EyeMed [19]
Network	Blue View Vision	Blue View Vision	EyeMed
Exam	100% (ded waived)	100% (ded waived)	100%
Contact Lenses	1 pair per calendar year	1 pair per calendar year	100%
Frames	1 pair per calendar year (ded waived)	1 pair per calendar year (ded waived)	1 pair per calendar year
Maximum Allowance per year	1 per calendar year	1 per calendar year	None
Pediatric Dental			
Carrier	Anthem Dental	Anthem Dental	Dental Benefit Providers [18, 19]
Network	Prime	Prime	Dental Benefit Providers
Deductible	Combined Med/Pediatric dental ded	Combined Med/Pediatric dental ded	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	50%	50%	Copay varies by service
Major Services (no waiting period)	50%	50%	Copay varies by service
Orthodontics (medically necessary)	50%	50%	Copay varies by service

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

1. See plan specific EOC for information on preventive services.
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. Limited to 100 4-hour visits per benefit period.
5. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
6. Evaluation only.
7. Maximum member responsibility.
8. Medical emergency only.
9. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
10. In an office setting.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
16. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
17. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
18. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
19. Pediatric dental and vision are included on all plans.
20. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

Services	HMO C	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$1,750 / $3,500 (applies to Max OOP)	$1,800 / $3,600[6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600	$7,800 / $15,600[7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$55 Copay (ded waived)
Specialist Visit (SPC)	$70 Copay (ded waived)	$75 Copay (ded waived)
Laboratory	$40 Copay	$25 Copay
X-Ray	$50 Copay	$55 Copay
MRI, CT and PET (office setting)	$300 Copay per procedure	$350 Copay per procedure
Hospital Services – In-Patient	60%	55%
In-Patient Physician Fees	60%	55%
Emergency Room (copay waived if admitted)	60%	55%
Urgent Care	$70 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 70%[14]	 55% 55%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$70 Copay (ded waived)	$75 Copay (ded waived)
Ambulance Services (per trip)	$300 Copay	55%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived)[16, 17] $250 / $500 Ded – 60% (up to $250 per prescription[12])[16, 17] $250 / $500 Ded – 60% (up to $250 per prescription[12])[16, 17] $250 / $500 Ded – 60% (up to $250 per prescription[16, 17])(prior auth. required)[16, 17]	 $20 Copay (ded waived) $350 / $700 Ded - $75 Copay $350 / $700 Ded - $75 Copay (with physician approval) $350 / $700 Ded – 80% (up to $250 per prescription[12])(with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$250 / $500 Ded –Applicable Rx Copay[16, 17]	$350 / $700 Ded - $75 Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[5]	100% (ded waived)[5]
Chronic Disease Management	$70 Copay (ded waived)	Covered as any Illness
Chemotherapy	100% (ded waived)	100% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	$15 Copay (ded waived)[13]
Acupuncture	$10 Copay (ded waived)[9]	$55 Copay (ded waived)[13]
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)[4]	$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived)[4]	$65 Copay (ded waived)

Silver HMO

Groups Beginning 7/1/20

Services	HMO C	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	$50 Copay (ded waived)	100% (ded waived) [1]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (ded waived) (no limit)	55%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%	55% (ded waived) [8]
Mental Health In-Patient Out-Patient (office visit)	 60% [18] $50 Copay (ded waived) [18]	 55% $55 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 55%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [10] EyeMed 100% (ded waived) 100% (ded waived) 1 pair per calendar year (ded waived) None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [15] 1 pair per calendar year (ded waived) [15] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [10, 11] Dental Benefit Providers None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [2] $365 Copay [3] $350 Copay

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
5. See plan specific EOC for information on preventive services.
6. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
7. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
8. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
9. Must be medically necessary.
10. Pediatric dental and vision are included on all plans.
11. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
12. Maximum member responsibility.
13. 20 visits max per year combined for Chiropractic and Acupuncture.
14. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
15. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
16. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
17. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
18. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

Services	HMO B	HMO C	HMO D† HSA Qualified
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,650 / $3,300 [3] (applies to Max OOP)	$2,250 / $4,500 [5] (applies to Max OOP)	$2,500 / $2,800 / $5,000 [7] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [8]	$7,800 / $15,600 [8]	$6,850 / $13,700 [8]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$55 Copay (ded waived)	$50 Copay (ded waived)	80%
Specialist Visit (SPC)	$80 Copay (ded waived)	$85 Copay (ded waived)	80%
Laboratory	$25 Copay (ded waived)	$40 Copay (ded waived)	80%
X-Ray	$75 Copay	$85 Copay (ded waived)	80%
MRI, CT and PET (office setting)	$350 Copay per procedure	$300 Copay per procedure (ded waived)	80% per procedure
Hospital Services – In-Patient	60%	80%	80%
In-Patient Physician Fees	60%	80%	80%
Emergency Room (copay waived if admitted)	60%	$400 Copay	80%
Urgent Care	$55 Copay (ded waived)	$50 Copay (ded waived)	80%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 80% (ded waived) 80% (ded waived)	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$80 Copay (ded waived)	$85 Copay (ded waived)	80%
Ambulance Services (per trip)	60%	$250 Copay	80%
Rx Benefits			
Generic	$20 Copay (ded waived)	$300 / $600 Ded – $17 Copay	80% (Up to $250 per prescription [9]) (combined Med/Rx ded)
Formulary Brand	$350 / $700 Ded – $75 Copay	$300 / $600 Ded – $65 Copay	80% (Up to $250 per prescription [9]) (combined Med/Rx ded)
Non-Formulary Brand	$350 / $700 Ded – $75 Copay (with physician approval)	$300 / $600 Ded – $65 Copay (with physician approval)	80% (Up to $250 per prescription [9]) (combined Med/Rx ded) (with physician approval)
Specialty	$350 / $700 Ded – 80% (up to $250 per prescription [9]) (with physician approval)	$300 / $600 Ded – 80% (up to $250 per prescription [9]) (with physician approval)	80% (up to $250 per prescription [9]) (combined Med/Rx ded) (with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$350 / $700 Ded – $75 Copay	$300 / $600 Ded – $65 Copay	80% (Up to $250 per prescription [9]) (combined Med/Rx ded)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100% (ded waived)	80% (ded waived)	80%
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [2]	Not Covered	Not Covered
Acupuncture	$55 Copay (ded waived) [2]	$50 Copay (ded waived)	80%
Physical, Occupational, Speech Therapy	$65 Copay (ded waived)	$50 Copay (ded waived)	80%
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived)	$50 Copay (ded waived)	80%

Silver HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C	HMO D† HSA Qualified
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	100% (ded waived) [10]	$45 Copay (ded waived) [10]	80% [10]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	80%	80%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	60% (ded waived) [6]	80% (ded waived) [6]	80% [6]
Mental Health In-Patient Out-Patient (office visit)	 60% $55 Copay (ded waived)	 80% $50 Copay (ded waived)	 80% 80%
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 80%	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [11] 1 pair per calendar year (ded waived) [11] None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [11] 1 pair per calendar year (ded waived) [11] None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [11] 1 pair per calendar year (ded waived) [11] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [4] $365 Copay [5] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [4] $365 Copay [5] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [4] $365 Copay [5] $350 Copay

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. 20 visits max per year combined for Chiropractic and Acupuncture.
3. 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.
4. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
5. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. $2,500 Self only enrollment, $2,800 for any one member within a Family enrollment. $5,000 for an entire Family. Does not apply to preventive care.
8. 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.
9. Maximum member responsibility.
10. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
11. 1 pair of glasses or 1 pair of contact lenses per accumulation period.

Services	HMO A	HMO B	HMO C
Participating Health Plans	Sharp	Sharp	Sharp
Network Name	Premier	Performance	Premier
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,300 / $4,600 [7] (applies to Max OOP)	$2,300 / $4,600 [7] (applies to Max OOP)	$2,500 / $5,000 [7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000 [2, 7]	$8,000 / $16,000 [2, 7]	$8,000 / $16,000 [2, 7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Specialist Visit (SPC)	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Laboratory	$15 Copay	$15 Copay	$15 Copay
X-Ray	$55 Copay	$50 Copay	$50 Copay
MRI, CT and PET (office setting)	$175 Copay per procedure	$175 Copay per procedure	$175 Copay per procedure
Hospital Services – In-Patient	$850 Copay per day	60%	50%
In-Patient Physician Fees	100%	60%	50%
Emergency Room (copay waived if admitted)	$700 Copay	60%	50%
Urgent Care	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 50% 50%	 60% 60%	 50% 50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Ambulance Services (per trip)	$400 Copay (ded waived)	60% (ded waived)	50% (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $200 / $400 Ded – $105 Copay $200 / $400 Ded – $135 Copay $200 / $400 Ded – Applicable Rx Copay	 $20 Copay (ded waived) $200 / $400 Ded – $100 Copay $200 / $400 Ded – $160 Copay $200 / $400 Ded – Applicable Rx Copay	 $20 Copay (overall ded waived) $100 Copay (overall ded waived) $150 Copay (overall ded waived) Applicable Rx Copay (overall ded waived)
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100% (overall ded waived)
Diabetes – Self-Injectable	$200 / $400 Ded – Applicable Rx Copay	$200 / $400 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	$800 Copay per day [8]	60% [8]	50% [8]
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Chemotherapy	Variable [3]	Variable [3]	Variable [3]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Physical, Occupational, Speech Therapy	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)

Silver HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	Sharp	Sharp	Sharp
Network Name	Premier	Performance	Premier
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day	60%	50%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health			
In-Patient	$125 Copay per day	60%	50%
Out-Patient (office visit)	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	$125 Copay per day	60%	50%
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	VSP	VSP
Network	VSP	VSP	VSP
Exam	100%	100%	100%
Contact Lenses	1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses
Frames	100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Access Dental	Access Dental	Access Dental
Network	Access Dental Plan Children's Dental HMO	Access Dental Plan Children's Dental HMO	Access Dental Plan Children's Dental HMO
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700 [4]	$350 / $700 [4]	$350 / $700 [4]
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	$25 Copay [5]	$25 Copay [5]	$25 Copay [5]
Major Services (no waiting period)	$350 Copay [6]	$350 Copay [6]	$350 Copay [6]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$350 Copay

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

1. See plan specific EOC for information on preventive services.
2. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
3. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
4. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
5. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
6. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
7. 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.
8. Amount listed for In-Patient Services only

Services	HMO B	HMO C† HSA Qualified	HMO A
Participating Health Plans	Sutter Health Plus	Sutter Health Plus	UnitedHealthcare
Network Name	Sutter Health Plus	Sutter Health Plus	SignatureValue
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,250 / $4,500 [7] (applies to Max OOP)	$2,500 / $2,800 / $5,000 [7, 10] (combined Med/Rx ded) (applies to Max OOP)	$2,250 / $4,500 [4] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [9]	$6,000 / $12,000 [9]	$8,150 / $16,300 [5]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived) [8]	$35 Copay [8]	$55 Copay (ded waived)
Specialist Visit (SPC)	$85 Copay (ded waived)	$50 Copay	$80 Copay (ded waived)
Laboratory	$40 Copay (ded waived)	$35 Copay	$45 Copay (ded waived)
X-Ray	$85 Copay per procedure (ded waived)	$15 Copay per procedure	$45 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay per procedure (ded waived)	$50 Copay per procedure	$200 Copay per procedure (ded waived)
Hospital Services – In-Patient	80%	80%	60%
In-Patient Physician Fees	80% (ded waived)	80%	60% (ded waived)
Emergency Room (copay waived if admitted)	$400 Copay	80%	60%
Urgent Care	$50 Copay (ded waived)	$35 Copay	$100 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% (ded waived) 80% (ded waived)	 80% 80%	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$85 Copay (ded waived)	$50 Copay	$80 Copay (ded waived)
Ambulance Services (per trip)	$250 Copay	80%	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $300 / $600 Ded – $17 Copay [11] $300 / $600 Ded – $65 Copay [11, 12] $300 / $600 Ded – $90 Copay [11, 12] $300 / $600 Ded – 80% (up to $250 per prescription [3]) [11, 12]	 $10 Copay (combined Med/Rx ded) [11] $20 Copay (combined Med/Rx ded) [11, 12] $40 Copay (combined Med/Rx ded) [11, 12] 80% (up to $250 per prescription [3]) (combined Med/Rx ded) [11, 12]	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [2] $300 / $600 Ded – $100 Copay [2] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$300 / $600 Ded – Applicable Rx Copay [11, 12]	Applicable Rx Copay (combined Med/Rx ded) [11, 12]	Applicable Ded / Rx Copay [2]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	80% (ded waived)	80%	$150 Copay (ded waived) [6]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	$15 Copay (ded waived)
Acupuncture	$50 Copay (ded waived)	$35 Copay	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	$35 Copay	$55 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived)	$35 Copay	$55 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	80%	$55 Copay (ded waived)

Silver HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C† HSA Qualified	HMO A
Participating Health Plans	Sutter Health Plus	Sutter Health Plus	UnitedHealthcare
Network Name	Sutter Health Plus	Sutter Health Plus	SignatureValue
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%	60%
Hospice (out-patient)	100% (ded waived)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived)	80%	$50 Copay (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 80% [13] $50 Copay (ded waived)	 80% [13] $35 Copay	 60% $55 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 80% [13]	 80% [13]	 60%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% (ded waived) [14] 100% (in lieu of eyeglasses) (ded waived) [14, 15] 100% (in lieu of contact lenses) (ded waived) [14, 15] 1 pair per year	 VSP Choice Network 100% (ded waived) [14] 100% (in lieu of eyeglasses) (ded waived) [14, 15] 100% (in lieu of contact lenses) (ded waived) [14, 15] 1 pair per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. For Specialty drugs, please see plan specific EOC.
3. Maximum member responsibility.
4. 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.
5. 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 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.
6. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
7. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
8. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
9. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
10. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
11. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

(Footnotes continued on page 94)

Services	HMO B	HMO C	HMO D
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Advantage	Alliance	Focus
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,250 / $4,500 [5] (applies to Max OOP)	$2,250 / $4,500 [5] (applies to Max OOP)	$2,250 / $4,500 [5] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,150 / $16,300 [6]	$8,150 / $16,300 [6]	$8,150 / $16,300 [6]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Specialist Visit (SPC)	$80 Copay (ded waived)	70%	$80 Copay (ded waived)
Laboratory	$45 Copay (ded waived)	70%	$45 Copay (ded waived)
X-Ray	$45 Copay (ded waived)	70%	$45 Copay (ded waived)
MRI, CT and PET (office setting)	$200 Copay per procedure (ded waived)	70%	$200 Copay per procedure (ded waived)
Hospital Services – In-Patient	60%	70%	60%
In-Patient Physician Fees	60% (ded waived)	70%	60% (ded waived)
Emergency Room (copay waived if admitted)	60%	70%	60%
Urgent Care	$100 Copay (ded waived)	70%	$100 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 70% 70%	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$80 Copay (ded waived)	70%	$80 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	70%	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [4] $300 / $600 Ded – $100 Copay [4] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [4]	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [4] $300 / $600 Ded – $100 Copay [4] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [4]	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [4] $300 / $600 Ded – $100 Copay [4] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [4]	Applicable Ded / Rx Copay [4]	Applicable Ded / Rx Copay [4]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay (ded waived) [2]	70%	$150 Copay (ded waived) [2]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	70%	$15 Copay (ded waived)
Acupuncture	$10 Copay (ded waived)	70%	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	70%	60%

Silver HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C	HMO D
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Advantage	Alliance	Focus
Metal Tier	**Silver**	**Silver**	**Silver**
Hospice (out-patient)	100% (ded waived)	70%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$50 Copay (ded waived)	70%	$50 Copay (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 60% $55 Copay (ded waived)	 70% 70%	 60% $55 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 70%	 60%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
3. Maximum member responsibility.
4. For Specialty drugs, please see plan specific EOC.
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. 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 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.

Services	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,300 / $4,600 [1, 10] (applies to Max OOP)	$2,250 / $4,500 [1, 10] (applies to Max OOP)	$2,500 / $2,800 / $5,000 [1, 9, 10] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [2, 10]	$7,800 / $15,600 [2, 10]	$6,850 / $13,700 [2, 10]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$50 Copay (ded waived)	80% [1, 4]
Specialist Visit (SPC)	$50 Copay (ded waived)	$85 Copay (ded waived)	80% [1, 4]
Laboratory	$50 Copay (ded waived)	$40 Copay (ded waived)	80% [1, 4]
X-Ray	$75 Copay (ded waived)	$85 Copay (ded waived)	80% [1, 4]
MRI, CT and PET (office setting)	$350 Copay (ded waived)	$300 Copay (ded waived)	80% [1, 4]
Hospital Services – In-Patient	70% [1, 4]	80% [1, 4]	80% [1, 4]
In-Patient Physician Fees	100% (ded waived)	80% (ded waived) [4]	80% [1, 4]
Emergency Room (copay waived if admitted)	70% [1, 4]	$400 Copay [1]	80% [1, 4]
Urgent Care	$100 Copay [1]	$50 Copay (ded waived)	80% [1, 4]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $350 Copay [1] $350 Copay [1]	 80% (ded waived) [4] 80% (ded waived) [4]	 80% [1, 4] 80% [1, 4]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay (ded waived)	$85 Copay (ded waived)	80% [1, 4]
Ambulance Services (per trip)	100% (ded waived)	$250 Copay [1]	80% [1, 4]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) $250 / $500 Ded – $55 Copay [1, 11] $250 / $500 Ded – $85 Copay [1, 11] $250 / $500 Ded – 70% (up to $250 per 30 day supply [8]) [1, 4]	 $300 / $600 Ded – $17 Copay [1] $300 / $600 Ded – $65 Copay [1, 11] $300 / $600 Ded – $90 Copay [1, 11] $300 / $600 Ded – 80% (up to $250 per 30 day supply [8]) [1, 4]	 80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4] 80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4, 11] 80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4, 11] 80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$250 / $500 Ded – $55 Copay [1]	$300 / $600 Ded – $65 Copay [1]	80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100% (ded waived)	80% [1, 4]	80% [1, 4]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$15 Copay (ded waived)	$15 Copay (ded waived)	100% [1]
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	$50 Copay (ded waived)	80% [1, 4]
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived)	$50 Copay (ded waived)	80% [1, 4]

Silver HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	100% (ded waived)	$45 Copay (ded waived)	80% [1, 4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70% [1, 4]	80% [1, 4]	80% [1, 4]
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) [4, 5]	80% (ded waived) [4, 5]	80% [1, 4, 5]
Mental Health In-Patient Out-Patient (office visit)	 70% [1, 4] $50 Copay (ded waived)	 80% [1, 4] $50 Copay (ded waived)	 80% [1, 4] 80% [1, 4]
Drug/Substance Abuse In-Patient (Detox Only)	 70% [1, 4]	 80% [1, 4]	 80% [1, 4]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [7]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [7]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [7]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deducible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. Limited to one pair of glasses with standard lenses or one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.
8. Maximum member responsibility.
9. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
10. 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.
11. 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.
12. Copayments do not contribute to out-of-pocket maximum.

Silver PPO

Groups Beginning 7/1/20

Services	**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[9]	In-Network	Out-of-Network[9]
Calendar Year Deductible*	$1,600 / $3,200 (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,200 / $6,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,700 / $3,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,400 / $6,800 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000[1]	$16,000 / $32,000[1]	$8,150 / $16,300[1]	$16,300 / $32,600[1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$45 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Specialist Visit (SPC)	$90 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
Laboratory	$45 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
X-Ray	$90 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
MRI, CT and PET (office setting)	60%	50% (up to $800 per test)[5]	65%	50% (up to $800 per test)[5]
Hospital Services – In-Patient	Tier 1: 60% Tier 2: $500 Copay per admit – 60%	50% (up to $650 per day)[5]	65%	50% (up to $650 per day)[5]
In-Patient Physician Fees	60%	50%	65%	50%
Emergency Room (copay waived if admitted)	$350 Copay – 60%		$300 Copay – 65%	
Urgent Care	$90 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 Tier 1: 60% Tier 2: $250 Copay per admit – 60% Tier 1: 60% Tier 2: $250 Copay per admit – 60%	 50% (up to $380 per admit)[5] 50% (up to $380 per admit)[5]	 $300 Copay per admit – 65% $300 Copay per admit – 65%	 50% (up to $380 per admit)[5] 50% (up to $380 per admit)[5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$90 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
Ambulance Services (per trip)	60%[13]		65%[13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived)[2] $350 / $700 Ded - $50 Copay[2] $350 / $700 Ded - $90 Copay[2] $350 / $700 Ded - 70% (up to $250 per prescription[8]) (prior auth.required)[2, 6]	 Not Covered Not Covered Not Covered Not Covered	 $20 Copay (ded waived)[2] $350 / $700 Ded – $50 Copay[2] $350 / $700 Ded – $90 Copay[2] $350 / $700 Ded – 70% (up to $250 per prescription[8]) (prior auth.required)[2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay[2]	Not Covered	Applicable Ded / Rx Copay[2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived)[3]	50%[3]	100% (ded waived)[3]	50%[3]
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	60%	50%[14]	65%	50%[14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period)[10]	Not Covered	50% (ded waived) (20 visits max per benefit period)[10]	Not Covered
Acupuncture	$45 Copay (ded waived)	Not Covered	$50 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$45 Copay (ded waived)	50%[14]	$50 Copay (ded waived)	50%[14]

Silver PPO

Groups Beginning 7/1/20

Services	**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 [9]	In-Network	Out-of-Network [9]
Rehabilitative & Habilitative Services and Devices	$45 Copay (ded waived) [11]	50% [11]	$50 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 60% [12] Tier 2: $500 Copay per admit – 60% [12]	50% (up to $150 per day) [5, 12]	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health In-Patient Out-Patient (office visit)	Tier 1: 60% Tier 2: $500 Copay per admit – 60% $45 Copay (ded waived)	50% (up to $650 per day) [5] 50%	65% $50 Copay (ded waived)	50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	Tier 1: 60% Tier 2: $500 Copay per admit – 60%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	$45 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	50% [7] Not Covered Not Covered Not Covered Not Covered	$50 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year) 1 per calendar year	Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

(Footnotes continued on page 94)

Services	PPO C	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Silver**	
	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$1,700 / $3,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,400 / $6,800 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,150 / $16,300 [1]	$16,300 / $32,600 [1]
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	$50 Copay (ded waived)	50%
Specialist Visit (SPC)	$95 Copay (ded waived)	50%
Laboratory	$50 Copay (ded waived)	50%
X-Ray	$95 Copay (ded waived)	50%
MRI, CT and PET (office setting)	65%	50% (up to $800 per test) [5]
Hospital Services – In-Patient	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%
Emergency Room (copay waived if admitted)	$300 Copay – 65%	
Urgent Care	$95 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay per admit – 65% $300 Copay per admit – 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required	
2nd Surgical Opinion	$95 Copay (ded waived)	50%
Ambulance Services (per trip)	65% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [2] $350 / $700 Ded – $50 Copay [2] $350 / $700 Ded – $90 Copay [2] $350 / $700 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness	
Chemotherapy	65%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$50 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	50% [14]
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]

Silver PPO

Groups Beginning 7/1/20

Services	PPO C	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	
Metal Tier	**Silver**	
	In-Network	Out-of-Network [9]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	
Mental Health In-Patient Out-Patient (office visit)	 65% $50 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 65%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $50 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

* All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. 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.

(Footnotes continued on page 94)

Services	EPO A	EPO B † HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer - Small Group	Prudent Buyer – Small Group
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,200 / $4,400 [2] (combined Med/ Pediatric dental ded)(applies to Max OOP)	$2,000 / $2,800 / $4,000 [9] (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,900 / $15,800 [3]	$6,750 / $13,500 [3]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived)	70%
Specialist Visit (SPC)	$100 Copay (ded waived)	70%
Laboratory	$50 Copay (ded waived)	70%
X-Ray	$100 Copay (ded waived)	70%
MRI, CT and PET (office setting)	65% [14]	70%
Hospital Services – In-Patient	65%	70%
In-Patient Physician Fees	65%	70%
Emergency Room (copay waived if admitted)	$300 Copay – 65%	70%
Urgent Care	$100 Copay (ded waived)	70%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay per admit – 65% $300 Copay per admit – 65%	 70% 70%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$100 Copay (ded waived)	70%
Ambulance Services (per trip)	65% [8]	70% [8]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [10] $300 / $600 Ded – $50 Copay [10] $300 / $600 Ded – $90 Copay [10] $300 / $600 Ded – 70% (up to $250 per prescription [7]) (prior auth. required) [5, 10]	 70% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [10] 70% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [10] 70% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [10] 70% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) (prior auth. required) [5, 10]
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [10]	Applicable Ded / Rx Copay [10]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	65%	70%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	50% (20 visits max per benefit period) [11]
Acupuncture	$50 Copay (ded waived)	70%
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	70%

Silver EPO

Groups Beginning 7/1/20

Services	EPO A	EPO B † HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group	Prudent Buyer – Small Group
Metal Tier	**Silver**	**Silver**
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [12]	70% [12]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	70% (Max 100 visits per benefit period) [4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [13]	70% [13]
Hospice (out-patient)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%
Mental Health In-Patient Out-Patient (office setting)	 65% $50 Copay (ded waived)	 70% 70%
Drug/Substance Abuse In-Patient (Detox Only)	 65%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $50 Copay (ded waived) [6] Not Covered Not Covered Not Covered Not Covered	 70% [6] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded Combined with Medical 100% 100% 50% 50% 50%

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. 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. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.
5. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
6. Evaluation only.
7. Maximum member responsibility.
8. Medical emergency only.
9. 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: $2,800 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.
10. The four prescription drug tiers are: tier 1 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.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Services	EPO A† HSA Qualified	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,500 / $2,800 / $5,000 [3] (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$2,250 / $4,500 (combined Med/ Pediatric dental ded)(applies to Max OOP)	$1,500 / $3,000 (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700	$7,800 / $15,600	$8,150 / $16,300
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	80%	$50 Copay (ded waived)	$50 Copay (ded waived)
Specialist Visit (SPC)	80%	$85 Copay (ded waived)	$75 Copay (ded waived)
Laboratory	80%	$40 Copay (ded waived)	$75 Copay (ded waived)
X-Ray	80% [8]	$85 Copay (ded waived) [8]	$75 Copay (ded waived) [8]
MRI, CT and PET (office setting)	80% [8]	$300 Copay (ded waived) [8]	50% [8]
Hospital Services – In-Patient	80%	80%	50%
In-Patient Physician Fees	80%	80% (ded waived)	50%
Emergency Room (copay waived if admitted)	80%	$400 Copay	$750 Copay (ded waived)
Urgent Care	80%	$50 Copay (ded waived)	$75 Copay (ded waived)
Hospital Services – Out-Patient			
Surgical Facility	80%	80% (ded waived)	50%
Ambulatory Surgery Center	80%	80% (ded waived)	50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	80% [6]	$85 Copay (ded waived) [6]	$75 Copay (ded waived) [6]
Ambulance Services (per trip)	80%	$250 Copay	$750 Copay (ded waived)
Rx Benefits			
Generic	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$300 / $600 Ded - $17 Copay	$25 Copay (ded waived)
Formulary Brand	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$300 / $600 Ded - $65 Copay	$55 Copay (ded waived)
Non-Formulary Brand	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$300 / $600 Ded - $90 Copay	$125 Copay (ded waived)
Specialty	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$300 / $600 Ded – 80% (up to $250 per prescription [4])	50% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded/Rx Copay	Applicable Ded/Rx Copay	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	80%	80% (ded waived)	50%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	80%	$50 Copay (ded waived)	$50 Copay (ded waived)
Physical, Occupational, Speech Therapy	80%	$50 Copay (ded waived)	$75 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	80% [7]	$50 Copay (ded waived) [7]	$75 Copay (ded waived) [7]

Silver EPO

Groups Beginning 7/1/20

Services	EPO A† (HSA Qualified)	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period)	$45 Copay (ded waived)(Max 100 visits per benefit period)	$75 Copay (ded waived)(Max 100 visits per benefit period)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%	50%
Hospice (out-patient)	100%	100% (ded waived)	50%
Durable Medical Equipment (Covered when medically necessary)	80% [9]	80% (ded waived) [9]	50% [9]
Mental Health			
In-Patient	80%	80%	50%
Out-Patient (office visit)	80%	$50 Copay (ded waived)	$50 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	80%	80%	50%
Infertility			
Infertility Evaluation and Treatment	Covered for Evaluation Only [5]	Covered for Evaluation Only [5]	Covered for Evaluation Only [5]
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Oscar	Oscar	Oscar
Network	Davis Vision	Davis Vision	Davis Vision
Exam	100% (ded waived) [2, 10]	100% (ded waived) [2, 10]	$75 Copay (ded waived) [2, 10]
Contact Lenses	100% (ded waived)(only in lieu of eyeglasses)	100% (ded waived)(only in lieu of eyeglasses)	50% (only in lieu of eyeglasses)
Frames	100% (ded waived)	100% (ded waived)	50%
Maximum Allowance per year	1 pair per calendar year	1 pair per calendar year	1 pair per calendar year
Pediatric Dental			
Carrier	Oscar	Oscar	Oscar
Network	Liberty	Liberty	Liberty
Deductible	Combined Med/Rx/Pediatric dental ded	Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100% (ded waived) [2]	100% (ded waived) [2]	100% (ded waived) [2]
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service (prior auth. required)	Copay varies by service (prior auth. required)	Copay varies by service (prior auth. required)
Orthodontics (medically necessary)	50% (ded waived) (prior auth. required)	$1,000 Copay (ded waived) (prior auth. required)	$1,000 Copay (ded waived) (prior auth. required)

† HSA Qualified High Deductible Plan
* All services are subject to the deductible unless otherwise stated.
1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
4. Maximum member responsibility.
5. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
6. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
8. Prior-Authorization may be required.
9. Prior-Authorization required if annual cost is greater than $500.
10. Limit one exam per 12 months.

Services	HMO A	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 (applies to Max OOP)	$6,300 / $12,600 [17] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600	$7,800 / $15,600 [2]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay [9]	$65 Copay [9]
Specialist Visit (SPC)	$95 Copay [9]	$95 Copay [9]
Laboratory	$40 Copay (ded waived)	$40 Copay (ded waived)
X-Ray	60%	60%
MRI, CT and PET (office setting)	60%	60% per procedure
Hospital Services – In-Patient	60%	60%
In-Patient Physician Fees	60%	60%
Emergency Room (copay waived if admitted)	60%	60%
Urgent Care	$65 Copay [9]	$65 Copay [9]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60% [11]	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$65 Copay [9]	$95 Copay [9]
Ambulance Services (per trip)	60%	60%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – $18 Copay [13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription [6]) [13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription [6]) [13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription [6])(prior auth. required) [13, 14]	 $500 / $1,000 Ded – $18 Copay $500 / $1,000 Ded – 60% (up to $500 per prescription [6]) $500 / $1,000 Ded – 60% (up to $500 per prescription [6])(with physician approval) $500 / $1,000 Ded – 60% (up to $500 per prescription [6])(with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – Applicable Rx Copay	$500 / $1,000 Ded – 60% (up to $500 per prescription [6])
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any illness
Preventive/Wellness Services	100% (ded waived) [4]	100% (ded waived) [4]
Chronic Disease Management	$95 Copay [9]	Covered as any illness
Chemotherapy	60%	60%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	$65 Copay [9, 16]	$65 Copay [9]
Physical, Occupational, Speech Therapy	$65 Copay (ded waived) [1]	$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived) [1]	$65 Copay (ded waived)

Bronze HMO

Groups Beginning 7/1/20

Services	HMO A	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	60% [10]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% (no limit)	60%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%	60%
Mental Health In-Patient Out-Patient (office visit)	 60% [15] $65 Copay (ded waived) [15]	 60% $65 Copay [9]
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 60%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [3] EyeMed 100% (ded waived) 100% (ded waived) 1 pair per calendar year (ded waived) None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [12] 1 pair per calendar year (ded waived) [12] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [3, 5] Dental Benefit Providers None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [7] $365 Copay [8] $350 Copay

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

1. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
2. 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.
3. Pediatric dental and vision are included on all plans.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
6. Maximum member responsibility.
7. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
8. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
9. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).
10. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
11. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
12. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
13. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
14. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
15. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
16. Must be medically necessary.
17. 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.

Services	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	\$6,900 / \$13,800 [12] (combined Med/Rx ded)(applies to Max OOP)	\$6,900 / \$13,800 [4] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,900 / \$13,800 [13]	\$7,900 / \$15,800 [4, 11]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	\$55 Copay
Specialist Visit (SPC)	100%	\$55 Copay
Laboratory	100%	\$15 Copay
X-Ray	100%	\$55 Copay
MRI, CT and PET (office setting)	100% per procedure	\$175 Copay per procedure
Hospital Services – In-Patient	100%	\$1,500 Copay per day – 3 days max
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	100%	\$500 Copay
Urgent Care	100%	\$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% 100%	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	100%	\$55 Copay
Ambulance Services (per trip)	100%	\$500 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) (with physician approval) 100% (combined Med/Rx ded) (with physician approval)	 \$19 Copay (ded waived) \$60 Copay (combined Med/Rx ded) \$100 Copay (combined Med/Rx ded) Applicable Rx Copay (combined Med/Rx ded)
Oral Contraceptives	100% (ded waived)	100% (if in formulary)
Diabetes – Self-Injectable	100% (combined Med/Rx ded)	Applicable Rx Copay (combined Med/Rx ded)
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	\$800 Copay per day – 3 days max [9]
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	Covered as any Illness	\$55 Copay
Chemotherapy	100%	Variable [8]
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	100%	\$55 Copay
Physical, Occupational, Speech Therapy	100%	\$55 Copay

Bronze HMO

Groups Beginning 7/1/20

Services	HMO C† (HSA Qualified)	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Rehabilitative & Habilitative Services and Devices	100%	$55 Copay
Home Health Care (Max 100 visits per year)	100% [1]	$55 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%	$25 Copay per day
Hospice (out-patient)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	100% [6]	50%
Mental Health		
In-Patient	100%	$125 Copay per day – 3 days max
Out-Patient (office visit)	100%	$55 Copay
Drug/Substance Abuse		
In-Patient (Detox Only)	100%	$125 Copay per day – 3 days max
Infertility		
Infertility Evaluation and Treatment	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	Kaiser Permanente	VSP
Network	Kaiser Permanente	VSP
Exam	100% (ded waived)	100%
Contact Lenses	1 pair per calendar year [10]	1 pair in lieu of eyeglasses
Frames	1 pair per calendar year (ded waived) [10]	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None
Pediatric Dental		
Carrier	Delta Dental	Access Dental
Network	DeltaCare USA	Access Dental Plan Children's Dental HMO
Deductible	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700 [7]
Office Visit	100% (ded waived)	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100%
Basic Services	$95 Copay [2]	$25 Copay [2]
Major Services (no waiting period)	$365 Copay [3]	$350 Copay [3]
Orthodontics (medically necessary)	$350 Copay	$350 Copay

† HSA Qualified High Deductible Plan

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. 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.
5. See plan specific EOC information on preventive services.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
8. Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
9. Amount listed for In-Patient Services only.
10. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
11. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
12. 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.
13. 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.

Services	HMO B† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sutter Health Plus
Network Name	Performance	Sutter Health Plus
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,650 / $11,300 [10] (combined Med/Rx ded)(applies to Max OOP)	$6,300 / $12,600 [1] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,650 / $13,300 [10, 17]	$7,800 / $15,600 [2]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$65 Copay [8, 9]
Specialist Visit (SPC)	60%	$95 Copay [8]
Laboratory	60%	$40 Copay (ded waived)
X-Ray	60%	60%
MRI, CT and PET (office setting)	60%	60%
Hospital Services – In-Patient	60%	60%
In-Patient Physician Fees	60%	60%
Emergency Room (copay waived if admitted)	60%	60%
Urgent Care	60%	$65 Copay [8]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	60%	$95 Copay [8]
Ambulance Services (per trip)	60%	60%
Rx Benefits		
Generic	60% (up to $500 per prescription [15]) (combined Med/Rx ded)	$500 / $1,000 Ded – $18 Copay [3]
Formulary Brand	60% (up to $500 per prescription [15]) (combined Med/Rx ded)	$500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4]
Non-Formulary Brand	60% (up to $500 per prescription [15]) (combined Med/Rx ded)	$500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4]
Specialty	60% (up to $500 per prescription [15]) (combined Med/Rx ded)	$500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4]
Oral Contraceptives	100% (if in formulary)	100% (ded waived)
Diabetes – Self-Injectable	60% (up to $500 per prescription [15]) (combined Med/Rx ded)	$500 / $1,000 Ded – Applicable Rx Copay [3, 4]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	60% [18]	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	60%	Covered as any Illness
Chemotherapy	Variable [11]	60%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	60%	$65 Copay [8]
Physical, Occupational, Speech Therapy	60%	$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	60%	$65 Copay (ded waived)
Home Health Care (Max 100 visits per year)	60%	60%

Bronze HMO

Groups Beginning 7/1/20

Services	HMO B† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sutter Health Plus
Network Name	Performance	Sutter Health Plus
Metal Tier	**Bronze**	**Bronze**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%
Hospice (out-patient)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	60%
Mental Health		
In-Patient	60%	60% [16]
Out-Patient (office visit)	60%	$65 Copay [8]
Drug/Substance Abuse		
In-Patient (Detox Only)	60%	60% [16]
Infertility		
Infertility Evaluation and Treatment	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	VSP	VSP
Network	VSP	Choice Network
Exam	100%	100% (ded waived) [6]
Contact Lenses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses) (ded waived) [6, 7]
Frames	100% (Pediatric Exchange collection only)	100% (in lieu of contact lenses) (ded waived) [6, 7]
Maximum Allowance per year	None	1 pair per year
Pediatric Dental		
Carrier	Access Dental	Delta Dental
Network	Access Dental Plan Children's Dental HMO	DeltaCare USA
Deductible	None	None
Out-of-Pocket Maximum	$350 / $700 [14]	Combined with Medical
Office Visit	100%	Copay varies by service (ded waived)
Diagnostic & Preventative (D&P)	100%	100% (ded waived)
Basic Services	$25 Copay [12]	Copay varies by service (ded waived)
Major Services (no waiting period)	$350 Copay [13]	Copay varies by service (ded waived)
Orthodontics (medically necessary)	$350 Copay	$1,000 Copay (ded waived)

† HSA Qualified High Deductible Plan

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

1. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
2. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
3. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
4. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
8. When outpatient benefits have Cost Sharing that includes "deductible waived for 1st 3 non-preventive visits", the Deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient MH/SUD visits.
9. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.

(Footnotes continued on page 94)

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plus	Alliance	Alliance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,900 / $13,800 [3] (combined Med/Rx ded) (applies to Max OOP)	$7,200 / $14,400 [2] (applies to Max OOP)	$6,900 / $13,800 [2] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,900 / $13,800 [5]	$8,150 / $16,300 [4]	$6,900 / $13,800 [4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	100% [7]	60%	100%
Specialist Visit (SPC)	100%	60%	100%
Laboratory	100%	60%	100%
X-Ray	100%	60%	100%
MRI, CT and PET (office setting)	100%	60%	100%
Hospital Services – In-Patient	100%	60%	100%
In-Patient Physician Fees	100%	60%	100%
Emergency Room (copay waived if admitted)	100%	60%	100%
Urgent Care	100%	60%	100%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% 100%	 60% 60%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	100%	60%	100%
Ambulance Services (per trip)	100%	60%	100%
Rx Benefits			
Generic	100% (combined Med/Rx ded) [9]	$20 Copay (ded waived)	100% (combined Med/Rx/Pediatric dental ded)
Formulary Brand	100% (combined Med/Rx ded) [9, 10]	$350 / $700 Ded – $50 Copay [6]	100% (combined Med/Rx/Pediatric dental ded) [6]
Non-Formulary Brand	100% (combined Med/Rx ded) [9, 10]	$350 / $700 Ded – $100 Copay [6]	100% (combined Med/Rx/Pediatric dental ded) [6]
Specialty	100% (combined Med/Rx ded) [9, 10]	$350 / $700 Ded – 60% (up to $500 per prescription [8]) [6]	100% (combined Med/Rx/Pediatric dental ded) [6]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (combined Med/Rx ded) [9]	Applicable Ded / Rx Copay [6]	100% (combined Med/Rx/Pediatric dental ded) [6]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	60%	100%
Chiropractic (20 visits max per year)	Not Covered	$15 Copay	100%
Acupuncture	100%	60%	100%
Physical, Occupational, Speech Therapy	100%	60%	100%
Rehabilitative & Habilitative Services and Devices	100%	60%	100%

Bronze HMO

Groups Beginning 7/1/20

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plus	Alliance	Alliance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	100%	60%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%	60%	100%
Hospice (out-patient)	100%	60%	100%
Durable Medical Equipment (Covered when medically necessary)	100%	60%	100%
Mental Health			
In-Patient	100% [13]	60%	100%
Out-Patient (office visit)	100%	60%	100%
Drug/Substance Abuse			
In-Patient (Detox Only)	100% [13]	60%	100%
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	Choice Network	Spectera Eyecare Networks	Spectera Eyecare Networks
Exam	100% (ded waived) [11]	100% (ded waived)	100% (ded waived)
Contact Lenses	100% (in lieu of eyeglasses) (ded waived) [11, 12]	60% (ded waived)	100%
Frames	100% (in lieu of contact lenses) (ded waived) [11, 12]	60% (ded waived)	100%
Maximum Allowance per year	1 pair per year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	Delta Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	DeltaCare USA	CA DHMO	CA DHMO
Deductible	None	None	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	Copay varies by service (ded waived)	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service (ded waived)	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay (ded waived)	$1,000 Copay	$1,000 Copay

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
3. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
4. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
5. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
6. For Specialty drugs, please see plan specific EOC.
7. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
8. Maximum member responsibility.

(Footnotes continued on page 94)

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 [1, 7] (applies to Max OOP)	$6,900 / $13,800 [1, 7] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [2, 7]	$6,900 / $13,800 [2, 7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay [9]	100% [1]
Specialist Visit (SPC)	$95 Copay [9]	100% [1]
Laboratory	$40 Copay (ded waived)	100% [1]
X-Ray	60% [1, 4]	100% [1]
MRI, CT and PET (office setting)	60% [1, 4]	100% [1]
Hospital Services – In-Patient	60% [1, 4]	100% [1]
In-Patient Physician Fees	60% [1, 4]	100% [1]
Emergency Room (copay waived if admitted)	60% [1, 4]	100% [1]
Urgent Care	$65 Copay [1]	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$95 Copay [9]	100% [1]
Ambulance Services (per trip)	60% [1, 4]	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – $18 Copay [1] $500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4, 11] $500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4, 11] $500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4]	 100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4]	100% (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	60% [1, 4]	100% [1]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$15 Copay [1]	100% [1]
Physical, Occupational, Speech Therapy	$65 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived)	100% [1]
Home Health Care (Max 100 visits per year)	60% [1, 4]	100% [1]

Bronze HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% [1, 4]	100% [1]
Hospice (out-patient)	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	60% [1, 4, 5]	100% [1]
Mental Health		
In-Patient	60% [1, 4]	100% [1]
Out-Patient (office visit)	$65 Copay [9]	100% [1]
Drug/Substance Abuse		
In-Patient (Detox Only)	60% [1, 11]	100% [1]
Infertility		
Infertility Evaluation and Treatment	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	MES Vision	MES Vision
Network	Eyewear Only	Eyewear Only
Exam	100% (ded waived)	100% (ded waived)
Contact Lenses	100% (ded waived)	100% (ded waived)
Frames	100% (ded waived)	100% (ded waived)
Maximum Allowance per year	1 per calendar year [10]	1 per calendar year [10]
Pediatric Dental		
Carrier	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA
Deductible	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Office Visit	100%	100%
Diagnostic & Preventative (D&P)	100%	100%
Basic Services	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.
8. Maximum member responsibility.
9. Deductible waived for first three non-preventive care visits.
10. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
11. 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.
12. Copayments do not contribute to out-of-pocket maximum

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$5,400 / $10,800 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$10,800 / $21,600 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$5,400 / $10,800 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$10,800 / $21,600 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,900 / $13,800 [1]	$13,800 / $27,600 [1]	$6,900 / $13,800 [1]	$13,800 / $27,600 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	65%	50%	65%	50%
Specialist Visit (SPC)	65%	50%	65%	50%
Laboratory	65%	50%	65%	50%
X-Ray	65%	50%	65%	50%
MRI, CT and PET (office setting)	65%	50% (up to $800 per test) [5]	65%	50% (up to $800 per test) [5]
Hospital Services –In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%		65%	
Urgent Care	65%	50%	65%	50%
Hospital Services – Out-Patient				
Surgical Facility	65%	50% (up to $380 per admit) [5]	65%	50% (up to $380 per admit) [5]
Ambulatory Surgery Center	65%	50% (up to $380 per admit) [5]	65%	50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	65%	50%	65%	50%
Ambulance Services (per trip)	65% [13]		65% [13]	
Rx Benefits				
Generic	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered
Formulary Brand	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered
Non-Formulary Brand	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered
Specialty	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2, 6]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2, 6]	Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	65%	50% [14]	65%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	65%	Not Covered	65%	Not Covered
Physical, Occupational, Speech Therapy	65%	50% [14]	65%	50% [14]

Bronze PPO

Groups Beginning 7/1/20

Services	**PPO A** † HSA Qualified		**PPO B** † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Rehabilitative & Habilitative Services and Devices	65% [11]	50% [11]	65% [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [12]	50% (up to $150 per day) [5, 12]	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health In-Patient Out-Patient (office visit)	 65% 65%	 50% (up to $650 per day) [5] 50%	 65% 65%	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 65%	 50% (up to $650 per day) [5]	 65%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 65% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 65% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

† HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.

(Footnotes continued on page 94)

Services	EPO A	EPO A† (HSA Qualified)	EPO B
Participating Health Plans	Anthem Blue Cross	Oscar	Oscar
Network Name	Prudent Buyer – Small Group	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,600 / $11,200 [1] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$6,900 / $13,800 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$8,150 / $16,300 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000 [2]	$6,900 / $13,800	$8,150 / $16,300
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay	100%	100%
Specialist Visit (SPC)	$85 Copay	100%	100%
Laboratory	60%	100%	100%
X-Ray	60%	100% [19]	100% [19]
MRI, CT and PET (office setting)	60% [14]	100% [19]	100% [19]
Hospital Services – In-Patient	60%	100%	100%
In-Patient Physician Fees	60%	100%	100%
Emergency Room (copay waived if admitted)	$300 Copay – 60%	100%	100%
Urgent Care	60%	100%	$75 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 100% 100%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$85 Copay	100% [18]	100% [18]
Ambulance Services (per trip)	60% [10]	100%	100%
Rx Benefits			
Generic	$20 Copay (ded waived) [9]	100% (combined Med/Rx/Pediatric dental ded)	100% (combined Med/Rx/Pediatric dental ded)
Formulary Brand	$60 Copay (combined Med/Rx/Pediatric dental ded) [9]	100% (combined Med/Rx/Pediatric dental ded)	100% (combined Med/Rx/Pediatric dental ded)
Non-Formulary Brand	$100 Copay (combined Med/Rx/Pediatric dental ded) [9]	100% (combined Med/Rx/Pediatric dental ded)	100% (combined Med/Rx/Pediatric dental ded)
Specialty	70% (up to $500 per prescription [3]) (prior auth. required) (combined Med/Rx/Pediatric dental ded) [4, 9]	100% (combined Med/Rx/Pediatric dental ded)	100% (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [9]	Applicable Ded/Rx Copay	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [6]	100% (ded waived) [6]	100% (ded waived) [6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	60%	100%	100%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	Not Covered	Not Covered
Acupuncture	$65 Copay	100%	100%
Physical, Occupational, Speech Therapy	60%	100%	100%
Rehabilitative & Habilitative Services and Devices	60% [12]	100% [16]	100% [16]

Bronze EPO

Groups Beginning 7/1/20

Services	EPO A	EPO A† HSA Qualified	EPO B
Participating Health Plans	Anthem Blue Cross	Oscar	Oscar
Network Name	Prudent Buyer – Small Group	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period)[5]	100% (Max 100 visits per benefit period)	100% (Max 100 visits per benefit period)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%[13]	100%	100%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	100%[20]	100%[20]
Mental Health			
In-Patient	60%	100%	100%
Out-Patient (office visit)	60%	100%	100%
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	100%	100%
Infertility			
Infertility Evaluation and Treatment	$65 Copay[7]	Covered for Evaluation Only[17]	Covered for Evaluation Only[17]
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	Oscar	Oscar
Network	Blue View Vision	Davis Vision	Davis Vision
Exam	100% (ded waived)	100% (ded waived)[8, 15]	100%[8, 15]
Contact Lenses	1 pair per calendar year	100% (ded waived) (only in lieu of eyeglasses)	100% (only in lieu of eyeglasses)
Frames	1 pair per calendar year (ded waived)	100% (ded waived)	100%
Maximum Allowance per year	1 per calendar year	1 pair per calendar year	1 pair per calendar year
Pediatric Dental			
Carrier	Anthem Dental	Oscar	Oscar
Network	Prime	Liberty	Liberty
Deductible	Combined Med/Rx/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100%	100% (ded waived)[15]	100% (ded waived)[15]
Basic Services	50%	Copay varies by service	Copay varies by service
Major Services (no waiting period)	50%	Copay varies by service (prior auth. required)	Copay varies by service (prior auth. required)
Orthodontics (medically necessary)	50%	50% (ded waived) (prior auth. required)	50% (ded waived) (prior auth. required)

† HSA Qualified High Deductible Plan

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

1. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
2. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family
3. Maximum member responsibility.
4. Classified specialty drugs must obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
5. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.
6. See plan specific EOC for information on preventive services.
7. Evaluation only.
8. Limit one exam per 12 months
9. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
10. Medical emergency only.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
16. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
17. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
18. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
19. Prior-Authorization may be required.
20. Prior-Authorization required if annual cost is greater than $500.

Gold HMO

(Footnotes continued from page 40)

12. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
13. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
14. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
15. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
16. Amount listed for In-Patient Services only.

Gold PPO

(Footnotes continued from page 48)

* All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. 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.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold PPO

(Footnotes continued from page 50)

* All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. 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.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold PPO

(Footnotes continued from page 52)

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

Additional Footnotes

Groups Beginning 7/1/20

Silver HMO

(Footnotes continued from page 66)

12. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
13. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
14. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
15. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.

Silver PPO

(Footnotes continued from page 72)

* All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. 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.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Silver PPO

(Footnotes continued from page 74)

10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Bronze HMO

(Footnotes continued from page 84)

10. In a high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum work differently. In a Self-Only coverage plan, you must meet the Self-Only Deductible and the Self -Only Out-of-Pocket Maximum. Once you meet the Self-Only Deductible, Sharp Health Plan will pay for your services. The Self-Only Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In a Family plan, each individual in the family must meet the Individual Deductible until the Family Deductible is met. Once an individual meets the Individual Deductible, Sharp Health Plan will pay for services for that individual in the family. Once the Family Deductible is met, Sharp Health Plan will pay for services for the entire family. All family members have met the Family Out-of-Pocket Maximum when the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum.
11. Copayment depends on type and location of service.
12. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
13. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
14. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children
15. Maximum member responsibility.
16. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
17. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.

Bronze HMO

(Footnotes continued from page 86)

9. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
10. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
11. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
12. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
13. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.

Bronze PPO

(Footnotes continued from page 90)

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

ADDITIONAL PRODUCTS & SERVICES

In addition to your health benefits, your CaliforniaChoice® plan offers various optional benefit options for members. Please note these optional benefits may vary depending on what your employer has decided to make available.

Dental

Reduced fees at Dentegra® Smile Club dentists, with no claims forms or waiting periods.

Vision

Discounts on frames, lenses, and exams at participating EyeMed Vision One Eyecare providers.

Hearing

Save up to 50% on brand-name hearing aids; enjoy other discounts on testing and batteries.

Chiro

Choose affordable Chiro Only or Chiro & Acupuncture benefits to improve your quality of life.

Life and AD&D

Life Insurance and AD&D give you the opportunity to provide for loved ones after you're gone.

Rx Discounts

Reduce your prescription drug cost to less than your Rx co-pay by using the California Rx Card.

Fitness and Wellness Discounts

Save on Garmin, Vitamix, and Fitbit products and get a gym membership for $25 per month.

Employee Discounts

Cal Perks offers savings on movies, theme parks, water parks, sporting event, and much more.

The CaliforniaChoice Member Value Suite

As part of the CaliforniaChoice commitment to helping members stay healthy, we offer free access to discounts on a variety of products and services through our Member Value Suite.

On the following pages you'll find a summary of each of the optional benefits. Each benefit and service available in the Member Value Suite is highlighted by this label:

Included in the Member Value Suite

DENTAL BENEFITS

Through CaliforniaChoice®, members have two options for Dental programs. Dentegra® Smile Club is included at no additional cost for all members enrolled in a Medical plan if your employer elects to offer it. Or, your employer may offer you DHMO or PPO Dental plans.

Please refer to your Personalized Enrollment Worksheet to view your specific dental benefit options.

Discount Dental

If you enroll in medical coverage through CaliforniaChoice, you are automatically eligible to enroll in the Dentegra Smile Club unless you enroll in a different Dental option made available by your employer. Dentegra allows you to visit a network of 20,000 providers. Just visit www.calchoice.com, login and click "Member Value Suites" and then "**Dentegra Discount Dental**". Then register* by clicking "Join the Club" and print your ID cards.

Because Dentegra is not Dental insurance, you pay the dentist directly for your care and receive a discount on the spot – with no waiting and no detailed claim forms to fill out.

*If you have any issues with registration, please contact Dentegra Customer Service at (877) 280-4204.

Comprehensive Employer-Sponsored and Voluntary Dental Plans

CaliforniaChoice also offers an optional Dental package that may be included in your Medical benefits program – if selected by your employer. This optional benefit package features a choice of DHMO and PPO Dental plans.

Dental Health Maintenance Organization (DHMO) Dental Plans
Members enrolled in a SmileSaver DHMO 1000 or 3000 plan will select a dentist from the extensive SmileSaver Dental provider network.

Preferred Provider Organization (PPO) Dental Plans
Members enrolled in a Ameritas PPO 3000, 3500, 4000, or 5000 plan are free to visit the dentist of your choice.

You can refer to your Personalized Enrollment Worksheet, or visit our website, www.calchoice.com, to view your specific Dental benefits.

There are three great ways to offer employees Dental.

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

SmileSaver℠ Dental 3000 and 1000 DHMO benefits are available for a low monthly payment and offers office visits, oral exams, X-rays, and 2 cleanings per year – FREE!

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

Both SmileSaver and Ameritas can be added as voluntary with no minimum employee participation, if offered by employer.

Plan Benefits	Dentegra Smile Club (Included in the Member Value Suite)	SmileSaver DHMO 3000	SmileSaver DHMO 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 on page 98

Continued from page 97

	Ameritas PPO 3000 5		Ameritas PPO 3500 5		Ameritas PPO 4000 5		Ameritas PPO 5000 5	
Plan Benefits	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Annual Maximum	$1,000	$600	$1,000[4]	$1,000[4]	$1,200[4]	$1,000[4]	$1,600[4]	$1,300[4]
Annual Deductible	$50 (Max 3x/Fam)	$100 (Max 3x/Fam)	$50 (Max 3x/Fam)	$50 (Max 3x/Fam)	$25 (Max 3x/Fam)	$75 (Max 3x/Fam)	$25 (Max 3x/Fam)	$75 (Max 3x/Fam)
Preventive Care	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies
Preventive	100%	80%	100%	100%	100%	80%	100%	80%
Basic	80%	80%	80%/90%/100%*	80%	80%/90%/100%*	80%	80%/90%/100%*	80%
Major (12 Month Wait)[1]	50%	50%	80%	50%	50%	50%	50%	50%
Endo/Perio	50%[1]	50%[1]	80%[1]	50%[1]	80% [1]	50%[1]	80% [1]	50%[1]
"Fusion" Vision Reimbursement Annual Maximum	N/A		$100**		$100**		$100**	

Orthodontia[3]	Ameritas PPO 3000 5		Ameritas PPO 3500 5		Ameritas PPO 4000 5		Ameritas PPO 5000 5	
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]	Not Covered	Not Covered	50%	50%	50%	50%	50%	50%
Annual Maximum	Not Covered	Not Covered	None	None	None	None	None	None
Lifetime Maximum	Not Covered	Not Covered	$1,000	$1,000	$1,000	$1,000	$1,000	$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 half of the annual maximum, 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 5	PPO 3500 5	PPO 4000 5	PPO 5000 5
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.
5. Please consult the applicable plan certificate for specific plan details.

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

Continued on page 99

Continued from page 98

AMERITAS EXTRAS*

Members enrolled on the Ameritas PPO 4000 or 5000 plan now have LASIK and Hearing Care coverage benefits!

These benefits are not tied to a network so members can seek services from any LASIK or hearing care provider. The benefits can even be used in conjunction with discounts or specials offered by the provider.

The LASIK benefit makes it more affordable for members to obtain laser vision corrections and reduce their dependency on glasses or contacts.

The hearing benefit provides coverage for an annual hearing exam and helps cover the cost of hearing devices and maintenance.

LASIK Lifetime Benefit per Eye[1]	Benefit
Lifetime maximum per person[2]	$175 if used in year 1 $175 if used in year 2 $350 if you wait and use it in year 3
Annual Hearing Exam Benefit[1]	$75
Hearing Aid Benefit per Ear[3,4]	$100 if used in year 1 $300 if used in year 2 $400 if used in year 3
Hearing Aid Maintenance Batteries, service contracts, fittings, ear mold and repairs	$40

* Lasik and Soundcare benefits are available to groups with 5+ enrolled Dental PPO members.

1. This is only a summary of benefits. Please consult Ameritas Certificate for complete coverage details.
2. The maximum is per eye and cannot be combined toward double coverage for a single eye
3. Once the hearing benefit is used, at any level, members become re-eligible for the benefit, at the top level, after five (5) years as long as there is not break in coverage. A reduced benefit is available after three (3) years if there is hearing deterioration the current aids can't correct, as long as there is no break in coverage.
4. Plan pays 50% of hearing aid cost up to the maximum benefit amount. The maximum is per ear and cannot be combined toward double coverage for a single ear.

VISION BENEFITS

The **Vision One Eyecare Discount Program** from EyeMed provided by Ameritas offers 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 vast network of doctors.

All CaliforniaChoice® members and their dependents are eligible for immediate savings through Vision One or may enroll a the Voluntary Vision Plan (if the employer elects to offer).

Included in the Member Value Suite

FREE Vision One Eyecare Discount Program by EyeMed provided by Ameritas

Save up to 40% on your eyecare needs

To find the provider closest to you, visit www.eyemedvisioncare.com and click on EyeMed Vision Care Providers. Discounted prices are automatically calculated, once eligibility is verified by the provider.

Save on Contact Lenses

To save on contact lenses, simply visit one of thousands of nationwide locations and save 15% off non-disposable contacts. You can also use the Contact Lens replacement program for additional savings and convenience. Details are available at www.eyemedcontacts.com or call 800.508.1399.

Vision One Features

- No claims to file
- No waiting for reimbursement
- Unlimited access

Voluntary Vision Program by EyeMed and VSP, both provided by Ameritas

Convenient Vision Care

Whether you enroll in the Voluntary Vision Plan by EyeMed or the Voluntary Vision Plan by VSP, you have a choice of retail optical locations and independent providers, making it convenient for you and your family to receive vision care.

How The Plan Works

After you enroll, you'll receive a brochure and Welcome Letter detailing your benefits. When using your benefits, simply go to a participating provider to receive services and eyewear.

Plan Features

When you visit an in-network provider, there is:

- No claim to file
- No waiting for reimbursement

You may use your benefits once every 12 months. Once you have exhausted your benefits, you will still receive applicable Vision Care discounts.

LASIK Surgery Discounts

With LASIK vision correction, millions of Americans have significantly reduced or eliminated their need for glasses or contact lenses. LASIK is an outpatient procedure that is virtually painless and provides near immediate results.

Both the Vision One Eyecare Discount Program and Voluntary Vision Program offer discounts on LASIK procedures.

TIPS FOR USING YOUR VISION BENEFITS

Be sure to call the optometrist in advance to make an appointment and verify participation.

For location information, please call CaliforniaChoice Customer Service Center at **800.558.8003** or go to **www.calchoice.com**.

Vision One Eyecare Discount Program by EyeMed provided by Ameritas

Eye Examinations*	Employee Savings
Routine Exam	$ 5 savings
Contact Lens Exam	$10 savings

Frames

Up to 40% off any frame available at provider locations.

Lenses	Employee Cost
Single Vision	$ 50
Bifocal	$ 70
Trifocal	$105

Lens Options	
Standard - progressive (no line bifocals; amount added to bifocal cost)	$ 65
Polycarbonate	$ 40
Scratch resistant coating	$ 15
Ultraviolet coating	$ 15
Solid or gradient tint	$ 15
Anti-reflective coating	$ 45
Photochromic	20% Discount

Contact Lenses (2 ways to save)

1. Visit one of thousands of nationwide locations and save 15% off non-disposable contacts.
2. Use the Contact Lens replacement program for additional savings and convenience. Details are available at **www.eyemedcontacts.com** or call 800.508.1399.

Participating providers are independent contractors solely responsible for vision examinations and products.

Pearle Vision, Inc. does not employ Doctors of Optometry and does not provide eye exams in California. Pearle VisionCare, Inc., a licensed vision healthcare service plan, provides eye exams in California.

Discounts cannot be used with other discounts, promotions, or prior orders.

Voluntary Vision by EyeMed provided by Ameritas

	Your In-Network Cost	Your Out-of-Network Reimbursements
Eye Examinations		
Routine Eye Exam (1 per 12 months)	$ 10	up to $ 20
Frames (choice of any available frame) (1 per 12 months)		
Up to $100	Covered in Full**	up to $ 30
** Plus 20% off balance over $100		
Lenses (standard uncoated plastic) (1 per 12 months)		
Single vision	$ 10	up to $ 20
Bifocal	$ 10	up to $ 30
Trifocal	$ 10	up to $ 40
Standard-progressive (no line bifocals; amount added to bifocal cost)	$ 75	up to $ 30
Lens Options (add to lens prices above)		
Anti-reflective coating	$ 45	Not Covered
Polycarbonate	$ 40	Not Covered
Scratch-resistant coating	$ 15	Not Covered
Ultraviolet coating	$ 15	Not Covered
Solid or gradient tint	$ 15	Not Covered
Photochromic	20% Discount	Not Covered
Contacts (one purchase per 12 months - in lieu of lenses and frames up to $100 retail value)		
Daily & extended wear	$ 10	$ 50
Disposable	$ 10	$ 50
Contact Lens Fitting		
Standard	Covered in Full	$ 40
Premium	90% of charges (less $40 allowance)[1]	$ 40

Participating retailers include: LensCrafters, Sears Optical, JCPenney, participating Pearle Vision Centers, Target Optical and many Independent Providers.

*Provided by licensed independent Doctors of Optometry.

1. Coinsurance is member responsibility.

Continued on page 102

Continued from page 101

Voluntary Vision by VSP provided by Ameritas

	Your In-Network Cost	Your Out-of-Network Reimbursement
Eye Examinations Routine Eye Exam (1 per 12 months)	$10	Up to $45
Frames (choice of any available frame) (1 per 12 month) [Up to $180]	Covered in Full	Up to $70
Lenses (1 per 12 months)		
Single Vision	$10	Up to $30
Bifocal	$10	Up to $50
Trifocal	$10	Up to $65
Standard Progressive (no line bifocals; amount added to bifocal cost)	$55	Up to $50
Lens Options (add to lens prices above)		
Anti-reflective coating	$43 - $85	Not Covered
Polycarbonate	Covered in full for dependent children, $33 adults	Not Covered
Scratch-resistant coating	$17 - $33	Not Covered
Ultraviolent coating	$16	Not Covered
Solid or gradient tint	$15 - $17	Not Covered
Photochromic	$31 - $82	Not Covered
Contacts (one purchase per 12 months – in lieu of lenses and frames up to $180 retail value)	$10	Up to $105
Contact Lens Fitting Elective	Covered in Full after member cost of up to $60	15% discount

CHIROPRACTIC BENEFITS

Half of America's workforce admits to having back problems. Chiropractic care can provide marked relief from pain and discomfort, while improving the quality of life and decreasing the likelihood of a recurrence.

CaliforniaChoice® offers low-cost chiropractic and acupuncture benefits for members through their employer. Your chiropractic benefits will depend on what your employer has selected to offer.

Chiropractic benefits appear on your Welcome Letter or can be viewed – along with your other optional benefits – online, anytime at www.calchoice.com.

Chiropractic/Acupuncture Benefits

by Landmark™ Healthplan

Landmark Healthplan Chiropractic and Acupuncture benefits are available for a low monthly Premium and affordable copays.

BENEFITS AVAILABLE THROUGH LANDMARK HEALTHPLAN

- Chiropractic and Acupuncture office visits
- Acupuncture treatment herbal therapies
- Acupuncture discounts on office visits, examinations, and all acupuncture procedures
- Chiropractic discounts on office visits, examinations, adjustments, diagnostic procedures and x-rays, and chiropractic medical appliances

For information on specific benefits available through the Chiropractic/Acupuncture program, see the full Summary of Benefits on page 104.

LANDMARK™ HEALTHPLAN CHIROPRACTIC SUMMARY OF BENEFITS

	Plan 1 †	Plan 2 †
	Chiro Only	**Chiro Only 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 Diagnostic Procedures and 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

* 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.

LIFE INSURANCE BENEFITS

Through CaliforniaChoice®, employers may elect to provide optional Life Insurance/AD&D coverage. If your employer has elected to offer Life Insurance, it will be available to you at no additional cost.

Life Insurance/AD&D by Assurity Life Insurance Company

This benefit allows you to provide for your 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 and increases based on the number of employees who enroll in the program at the time of the initial enrollment.

Assurity Life also provides a partial payment of the life insurance amount to policyholders who become terminally ill through the Living Benefits Provision.

Policyholders may also exercise a Conversion Privilege if you leave your job, are terminated, or otherwise terminate 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
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.

DISCOUNT RX CARD

Included in the Member Value Suite

Just what the doctor ordered: prescription drug savings

As a CaliforniaChoice® member, you're eligible to receive a California Rx Card, which offers prescription drug savings of up to 80% at more than 68,000 pharmacies nationwide.

There is no charge for the card and there are no waiting periods. In addition, there is no limit on your available savings. You can even use the card to save on pet medications.

Find a pharmacy in your area – and get prescription pricing information – at the California Rx Card website.

Cardholders have saved more than $681 million since the California Rx Card launched in 2007. Plus, each time you use the card, a donation goes to your local Children's Miracle Network hospital.

Look for the California Rx Card flyer in your CaliforniaChoice membership materials, or visit calchoice.com and click on **Rx Discounts** to start saving today.

Start saving today by taking your prescription and California Rx Card to your favorite pharmacy, including any of these regional and national drug stores and supermarket locations:

- ALBERTSONS
- CVS
- CVS@TARGET
- KMART
- RALEY'S
- RALPHS
- RITE AID
- SAFEWAY/PAVILIONS/VONS
- WALGREENS
- WALMART

FITNESS & WELLNESS DISCOUNTS

We want to help CaliforniaChoice® members stay healthy – both today and for the long term.

Through our partnership with American Specialty Health (ASH), the ChooseHealthy® program gives you exclusive savings on a variety of health and wellness products at negotiated prices:

Included in the Member Value Suite

- Get discounts of up to 57% on popular health and fitness brands
- Access online health classes and articles offered at no cost
- Enroll in the Active&Fit Direct™ program and choose from 10,000 participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes)
  - > Take advantage of online fitness tracking
  - > Search easily online for a location convenient to your work or home
  - > Use a guest pass to find a fitness center that's right for you – and enjoy the freedom to switch centers anytime, based on your individual needs

With ChooseHealthy, you'll save on top brands, including:

fitbit GARMIN PRO COMPRESSION Vitamix

Look for the ChooseHealthy flyer in your CaliforniaChoice membership materials, or visit calchoice.com and click on the **Member Value Suite** to take advantage of big savings.

Please note: the ChooseHealthy program is not insurance. It provides access to the Active&Fit Direct program, which provides discounted access to fitness centers. The ChooseHealthy program does not make any payments directly to the Active&Fit Direct program. The ChooseHealthy program has no liability for providing or guaranteeing services and assumes no liability for the quality of services rendered.

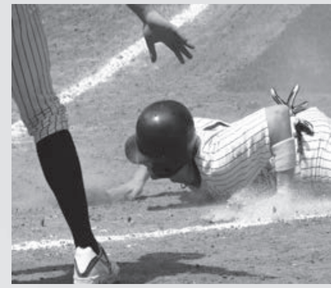
Discounts on products and services available through the ChooseHealthy program are subject to change; please consult the website for current availability.

The ChooseHealthy program is provided by ChooseHealthy, Inc., and the Active&Fit Direct program is provided by American Specialty Health Fitness, Inc., both subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy and Active&Fit Direct are trademarks of ASH and used with permission herein. Other names and logos may be trademarks of their respective owners.

Included in the Member Value Suite

Cal Perks discounts

FREE for all CaliforniaChoice® members



With Cal Perks you'll find huge discounts on entertainment, movies, products, services, hotels, amusement parks, rental cars, and more!

CAL PERKS

Cal Perks gives you big savings on attractions throughout California including theme parks, museums, movie theaters, golf, and sporting events. You'll also find great deals on products and services like flowers, dry cleaning, hotels, and warehouse store memberships, plus a whole lot more.

Since Cal Perks is always online, you can discover your discounts when it's convenient for you – 24 hours a day, 7 days a week. You will receive your discounts through promo codes, coupons, or purchasing items directly from partner vendor sites. Be sure to sign up for your FREE Cal Perks newsletter – e-Perk Update – at the Cal Perks website, to keep you up-to-date on new vendors and discounts.

Here are some of the places you'll discover discounts through Cal Perks:

- Universal Studios
- California's Great America
- San Jose Earthquakes
- LA Galaxy
- Sam's Club
- Budget Rent-A-Car
- Magic Mountain
- AMC Theatres
- DirecTV
- SuperShuttle

Click on "Cal Perks" at www.calchoice.com

Included in the Member Value Suite

Hearing loss is the third most chronic ailment in the nation with more than 33 million Americans suffering from some type of hearing loss. While hearing loss is usually treatable, 80% of adults don't get treatment.

The quality of your life can depend heavily on how well you hear. That's why CaliforniaChoice® has selected EPIC Hearing Service Plan to provide a free hearing program to our valued members. EPIC features an unprecedented national standard for high-quality hearing healthcare by offering expert testing, effective treatment, and advanced technology.

HEARING BENEFITS

FREE EPIC Hearing Service Plan (HSP)

for all CaliforniaChoice Members

The EPIC Hearing Service Plan starts with a 5-step evaluation of your ears and hearing that includes:

1. **Pure Tone Hearing Test** to determine if a hearing problem exists.
2. **Functional Assessment** to define the magnitude of the problem and the technology best suited to treat it.
3. **Hearing Aid Evaluation** to assess your ability to wear a hearing aid and select the best make and model.
4. **Fitting and Programming** your hearing aid.
5. **Therapy and Training** to finely tune your device and maximize the benefits that you receive.

You get great savings on hearing tests, hearing aids, hearing aid batteries, ear protection, swim plugs, musician ear plugs, hearing aid cleaning supplies and accessories, assistive listening devices, TV ears, telephone amplification, and altering and signaling devices.

Hearing Program Features

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

GETTING STARTED

1. Visit calchoice.com or Call EPIC at **866.956.5400**.
2. A hearing counselor will register you and help you determine your hearing-care needs.
3. EPIC will send you an HSP booklet that outlines the plan benefits, services, and pricing.
4. A hearing counselor will refer you to a provider near your home or work.
5. You can contact the provider to schedule an appointment, examination, and treatment anytime!

For information, advice, or assistance, contact EPIC at **866.956.5400**. EPIC will help you coordinate any insurance benefits or coverage where applicable.

After receiving treatment, EPIC will coordinate and manage all payments.

Life is good when you have **Choice**®

If you have any questions regarding coverage through the CaliforniaChoice® program, including enrollment, please call the CaliforniaChoice Customer Service Center at **(800) 558-8003**. Or contact any of our participating health plans at the numbers listed below.

Anthem Blue Cross	(855) 383-7248	Sharp Health Plan	(800) 359-2002
Health Net	(800) 361-3366	Sutter Health Plus	(855) 315-5800
Kaiser Permanente (English)	(800) 464-4000	UnitedHealthcare	(800) 624-8822
Kaiser Permanente (Spanish)	(800) 788-0616	Western Health Advantage	(888) 563-2250
Oscar	(855) 672-2755		

calchoice.com

CaliforniaChoice®
Your Health. Your Choice.®

CC0300_4.20_Eff.7.1.20