CaliforniaChoice®
Your Health. Your Choice.®

member enrollment guide

Groups Beginning 10/1/17

Anthem BlueCross · Health Net · KAISER PERMANENTE · SHARP HEALTH PLAN make life better. · 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, HSPs, 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.

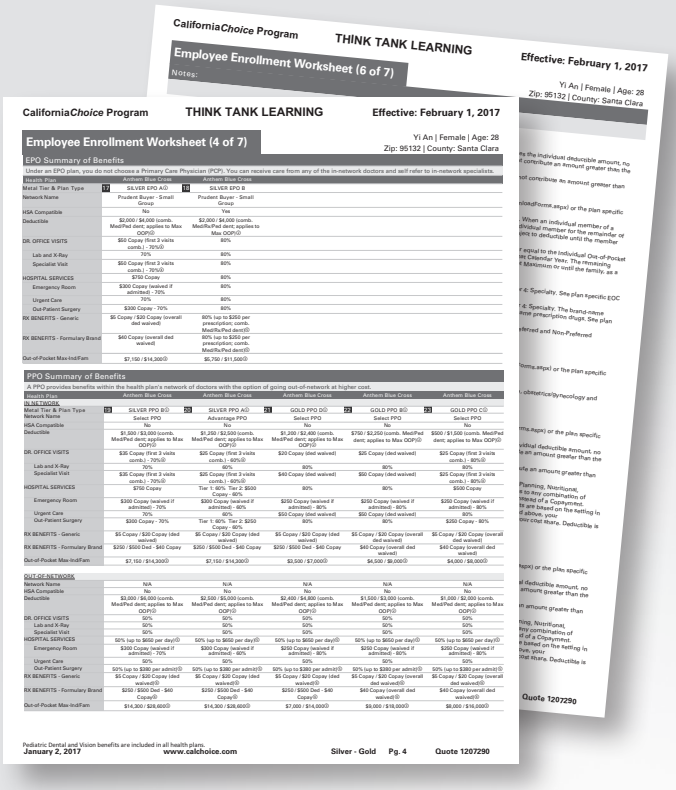
Programs that help you stay healthy and save

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 California*Choice*® Program and are accurate to the best of our knowledge at the time of print. If the information in this brochure differs from the information in the SBC (Summary of Benefits and Coverage), EOC (Evidence of Coverage) or COI (Certificate of Insurance), the EOC or COI applies.

TABLE OF CONTENTS



CaliforniaChoice Program THINK THANK LEARNING

Employee Enrollment Worksheet (6 of 7)

Notes:

Effective: February 1, 2017

Yi An | Female | Age: 28

Zip: 95132 | County: Santa Clara

CaliforniaChoice Program THINK THANK LEARNING Effective: February 1, 2017

Employee Enrollment Worksheet (4 of 7)

Yi An | Female | Age: 28

Zip: 95132 | County: Santa Clara

EPO Summary of Benefits

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 we'll refer to in-network specialists.

Health Plan	Anthem Blue Cross	Anthem Blue Cross
Metal Tier & Plan Type	71 SILVER EPO A/O	72 SILVER EPO B
Network Name	Prudent Buyer - Small Group	Prudent Buyer - Small Group
HSA Compatible	No	Yes
Deductible	$2,000 / $4,000 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$2,900 / $6,000 (comb. Med/Ru/Ped dent; applies to Max OOP)Ⓞ
DR. OFFICE VISITS		
Lab and X-Ray	$50 Copay (first 3 visits comb.) - 70%Ⓞ	80%
Specialist Visit	70%	80%
HOSPITAL SERVICES	$50 Copay (first 3 visits comb.) - 70%	80%
Emergency Room	$750 Copay	80%
Urgent Care	$300 Copay (waived if admitted) - 70%	80%
Out-Patient Surgery	70%	80%
RX BENEFITS - Generic	$300 Copay - 70%	80%
RX BENEFITS - Formulary Brand	$5 Copay / $20 Copay (overall ded waived)	80% (up to $250 per prescription; comb. Med/Ru/Ped dent)Ⓞ
Out-of-Pocket Max-Ind/Fam	$40 Copay (overall ded waived)	80% (up to $250 per prescription; comb. Med/Ru/Ped dent)Ⓞ
	$7,150 / $14,300Ⓞ	$6,750 / $11,500Ⓞ

PPO Summary of Benefits

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

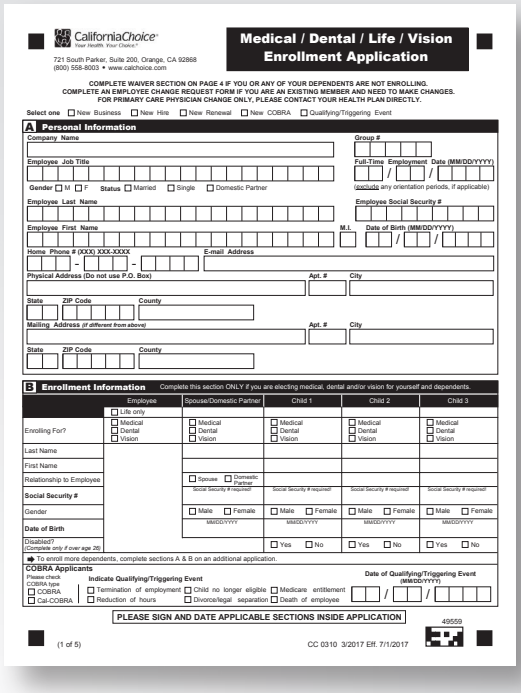
Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN-NETWORK					
Metal Tier & Plan Type	61 SILVER PPO B/Ⓞ	62 SILVER PPO A/Ⓞ	63 GOLD PPO D/Ⓞ	64 GOLD PPO B/Ⓞ	65 GOLD PPO C/Ⓞ
Network Name	Select PPO	Advantage PPO	Select PPO	Select PPO	Select PPO
HSA Compatible	No	No	No	No	No
Deductible	$1,500 / $3,000 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$1,250 / $2,500 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$1,200 / $2,400 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$750 / $2,250 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$500 / $1,500 (comb. Med/Ped dent; applies to Max OOP)Ⓞ
DR. OFFICE VISITS					
Lab and X-Ray	$35 Copay (first 3 visits comb.) - 70%Ⓞ	$25 Copay (first 3 visits comb.) - 60%Ⓞ	$20 Copay (ded waived)	$25 Copay (ded waived)	$25 Copay (first 3 visits comb.) - 80%Ⓞ
Specialist Visit	70%	60%	80%	80%	80%
HOSPITAL SERVICES	$35 Copay (first 3 visits comb.) - 70%Ⓞ	$25 Copay (first 3 visits comb.) - 60%Ⓞ	$40 Copay (ded waived)	$50 Copay (ded waived)	$25 Copay (first 3 visits comb.) - 80%Ⓞ
Emergency Room	$750 Copay	Tier 1: $500 Copay - 60% Tier 2: $500 Copay - 60%	80%	80%	$500 Copay
Urgent Care	$300 Copay (waived if admitted) - 70%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%
Out-Patient Surgery	70%	60%	$50 Copay (ded waived)	$50 Copay (ded waived)	80%
RX BENEFITS - Generic	$300 Copay - 70%	Tier 1: 60% Tier 2: $250 Copay - 60%	80%	80%	$250 Copay - 80%
RX BENEFITS - Formulary Brand	$5 Copay / $20 Copay (ded waived)	$6 Copay / $30 Copay (ded waived)	$5 Copay / $20 Copay (ded waived)	$5 Copay / $20 Copay (overall ded waived)	$5 Copay / $20 Copay (overall ded waived)
Out-of-Pocket Max-Ind/Fam	$250 / $500 Ded - $40 Copay	$250 / $500 Ded - $40 Copay	$250 / $500 Ded - $40 Copay	$40 Copay (overall ded waived)	$40 Copay (overall ded waived)
	$7,150 / $14,300Ⓞ	$7,150 / $14,300Ⓞ	$3,500 / $7,000Ⓞ	$4,500 / $9,000Ⓞ	$4,000 / $8,000Ⓞ
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$3,000 / $6,000 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$2,500 / $5,000 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$2,400 / $4,800 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$1,500 / $3,000 (comb. Med/Ped dent; applies to Max OOP)Ⓞ	$1,000 / $2,000 (comb. Med/Ped dent; applies to Max OOP)Ⓞ
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)Ⓞ	50% (up to $650 per day)Ⓞ	50% (up to $650 per day)Ⓞ	50% (up to $650 per day)Ⓞ	50% (up to $650 per day)Ⓞ
Emergency Room	$300 Copay (waived if admitted) - 70%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)Ⓞ	50% (up to $380 per admit)Ⓞ	50% (up to $380 per admit)Ⓞ	50% (up to $380 per admit)Ⓞ	50% (up to $380 per admit)Ⓞ
RX BENEFITS - Generic	$5 Copay / $30 Copay (ded waived)Ⓞ	$6 Copay / $30 Copay (ded waived)Ⓞ	$5 Copay / $30 Copay (ded waived)Ⓞ	$5 Copay / $30 Copay (overall ded waived)Ⓞ	$5 Copay / $30 Copay (overall ded waived)Ⓞ
RX BENEFITS - Formulary Brand	$250 / $500 Ded - $40 Copay/Ⓞ	$250 / $500 Ded - $40 Copay/Ⓞ	$250 / $500 Ded - $40 Copay/Ⓞ	$40 Copay (overall ded waived)Ⓞ	$40 Copay (overall ded waived)Ⓞ
Out-of-Pocket Max-Ind/Fam	$14,300 / $28,600Ⓞ	$14,300 / $28,600Ⓞ	$7,000 / $14,000Ⓞ	$9,000 / $18,000Ⓞ	$8,000 / $16,000Ⓞ

Pediatric Dental and Vision benefits are included in all health plans.

January 2, 2017 www.calchoice.com Silver - Gold Pg. 4 Quote 1207290

Quote 1207290

Personalized Enrollment Worksheet



CaliforniaChoice

Your Health. Your Choice.

721 South Parker, Suite 200, Orange, CA 92868

(800) 558-8003 • www.calchoice.com

Medical / Dental / Life / Vision Enrollment Application

COMPLETE WAIVER SECTION ON PAGE 4 IF YOU OR ANY OF YOUR DEPENDENTS ARE NOT ENROLLING.
COMPLETE AN EMPLOYEE CHANGE REQUEST FORM IF YOU ARE AN EXISTING MEMBER AND NEED TO MAKE CHANGES.
FOR PRIMARY CARE PHYSICIAN CHANGE ONLY, PLEASE CONTACT YOUR HEALTH PLAN DIRECTLY.

Select one ☐ New Business ☐ New Hire ☐ New Renewal ☐ New COBRA ☐ Qualifying/Triggering Event

A Personal Information

Company Name | Group #

Employee Job Title | Full-Time Employment Date (MM/DD/YYYY) (exclude any orientation periods, if applicable)

Gender ☐ M ☐ F Status ☐ Married ☐ Single ☐ Domestic Partner

Employee Last Name | Employee Social Security #

Employee First Name | M.I. | Date of Birth (MM/DD/YYYY)

Home Phone # (XXX) XXX-XXXX | E-mail Address

Physical Address (Do not use P.O. Box) | Apt. # | City

State | ZIP Code | County

Mailing Address (If different from above) | Apt. # | City

State | ZIP Code | County

B Enrollment Information Complete this section ONLY if you are electing medical, dental and/or vision for yourself and dependents.

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
	☐ Life only				
Enrolling For?	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision
Last Name					
First Name					
Relationship to Employee		☐ Spouse ☐ Domestic Partner			
Social Security #		Social Security # required	Social Security # required	Social Security # required	Social Security # required
Gender		☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Disabled? (Complete only if over age 26)			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

➡ To enroll more dependents, complete sections A & B on an additional application.

COBRA Applicants

Please check COBRA type ☐ COBRA ☐ Cal-COBRA

Indicate Qualifying/Triggering Event

☐ Termination of employment ☐ Reduction of hours ☐ Child no longer eligible ☐ Divorce/legal separation ☐ Medicare entitlement ☐ Death of employee

Date of Qualifying/Triggering Event (MM/DD/YYYY)

PLEASE SIGN AND DATE APPLICABLE SECTIONS INSIDE APPLICATION

49559

(1 of 5) CC 0310 3/2017 Eff. 7/1/2017

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 California*Choice*® 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 California*Choice* 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.

WELCOME TO CALIFORNIA*CHOICE*®

Healthcare for the Way We Live®

CONGRATULATIONS!

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

Anthem BlueCross

Health Net®

KAISER PERMANENTE®

SHARP HEALTH PLAN make life better.

Sutter Health Plus Your Health Plan

UnitedHealthcare®

Western Health Advantage

What is California*Choice*?

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

California*Choice* 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: **Platinum, Gold, Silver, and Bronze**. Each tier offers a variety of health and benefit plans. Your employer has selected a tier to make available to you. Or, your employer may have elected Tiered Choice, which offers access to two neighboring metal tiers (Platinum/Gold, Gold/Silver, or Silver/Bronze). You have the freedom to choose the health and benefit plans that you like best within the tier(s) selected by your employer.

What you have access to with California*Choice*

- A great selection of HMO, HSP, EPO, and PPO benefit plans to choose from
- A choice of seven of California's leading health plans
- Prepaid 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.

THE PERKS OF **BEING A MEMBER**

California*Choice*® offers our members more than just access to quality health care. As a California*Choice* member you'll discover a wide selection of benefits and services that help you save time, save money, and help you and your family stay healthy.

Manage your benefits online

California*Choice* 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!

Cal Perks discounts
FREE for all California*Choice*® members

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

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.

CAL PERKS

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

YOUR BENEFIT CHOICES

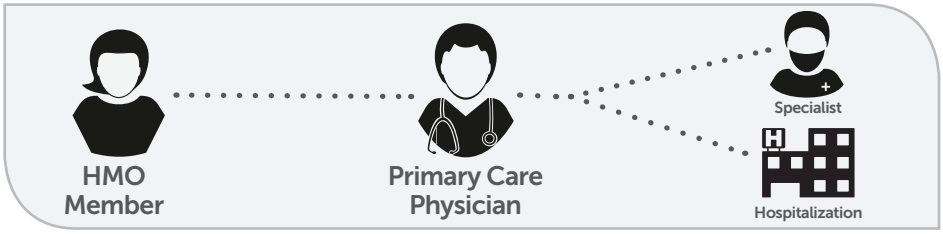
CaliforniaChoice® offers you a variety of plan types to choose from–helping you balance your health needs with your budget.

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. Like with an HMO plan, HSP members choose a PCP, but may go directly to any in-network specialists without a referral. With a PPO 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).

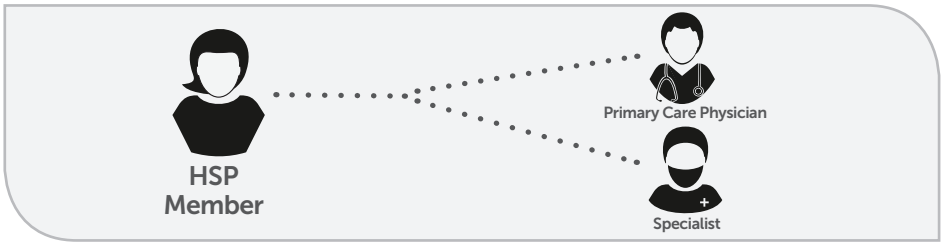
- First select a PCP. Referrals to hospitals and specialists are managed by your PCP.
- You pay a low copayment for each office visit.



Health Care Service Plan (HSP)

With an HSP, all services are received through in-network providers.

- HSPs require members to pick a Primary Care Physician (PCP).
- Members do not need a referral from their PCP to receive services from in-network specialists.



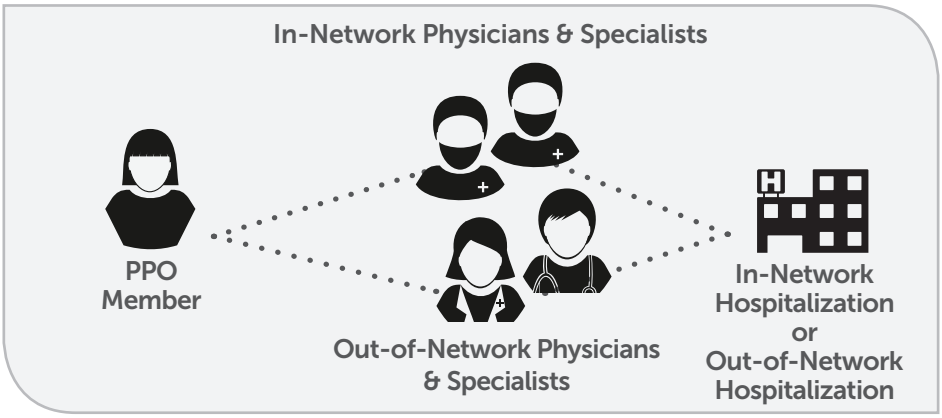
Exclusive Provider Organization (EPO)

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'd like to control my expenses.

You want to control what you pay for health care, but also want some freedom in selecting your specialist providers.

CONSIDER A HEALTHCARE SERVICE PLAN

A Healthcare Service Plan (HSP) is similar to an HMO, because you need to select a Primary Care Physician for your routine care. However, an HSP does allow you to schedule your own specialist visits without a referral, if the specialty provider is part of your HSP network.

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.

Discover the Anthem Difference.

Anthem Blue Cross is an accredited health plan that meets or exceeds national standards for quality care. Anthem is focused on your needs – both now and in the future – with health tools like personalized alerts and messages, an electronic health record, and apps that let you find a doctor on your mobile phone.

Anthem Benefits Overview

- One of the largest PPO networks in the country with access to thousands of doctors and specialists
- Preventive care benefits at no charge
- Dedicated local member support team
- Claims status 24/7 via telephone or online
- 24/7 NurseLine – toll-free access to medical information from registered nurses
- Special Offers program for discounts on healthy products and services
- Wellness programs and tools to keep you active and fit
- Tools to manage your health and costs

Local. Affordable. Easy.

Make this your year for health 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 30 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 network of 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
- Strength and stability. A Fortune 500 company, Health Net will support your health today and for decades to come – just like we've been doing for the last 30 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

- 6.5 million members in California, 8.7 million nationwide
- More than 9,000 physicians provide care at over 300 medical offices and 50 medical centers throughout California
- 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

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 800 primary care physicians, 1,300 specialists, and 12 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

California*Choice*® 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.

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 you deserve.

UnitedHealthcare of California provides the quality of care you deserve and the protection you need to manage your family's health care costs. Our large California HMO network includes local physicians and health care professionals in your community that you know and trust. With a combination of benefits, quality care, wellness programs to help keep you and your family healthy and award-winning customer service – 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 covered for every member of the family
- Fitness reimbursement program
- NurseLine℠, providing 24/7 access to registered nurses[1]
- Worldwide emergency coverage

Quality choices and flexibility.

Western Health Advantage lets you visit doctors, specialists, and hospitals in the Sacramento and Solano regions. Western Health Advantage will be there to help you every step of the way – with an actual person on the other end of the line. Members have access to education and wellness programs through affiliated medical groups and facilities.

Western Health Advantage Benefits Overview

- Choice of specialist with access to more than 2,200 specialists in Northern California within any of our medical groups – not just your particular medical group
- Tools for healthy living with Healthyroads™ online tools such as personal health assessment and customized meal and exercise plans
- Travel assistance service
- 24/7 nurse advice
- Manage your health coverage online and enjoy instant, secure access to your personal health plan information

[1] NurseLine℠ is for informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. NurseLine services are not an insurance program and may be discontinued at any time.

Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by United HealthCare Services, Inc., 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.

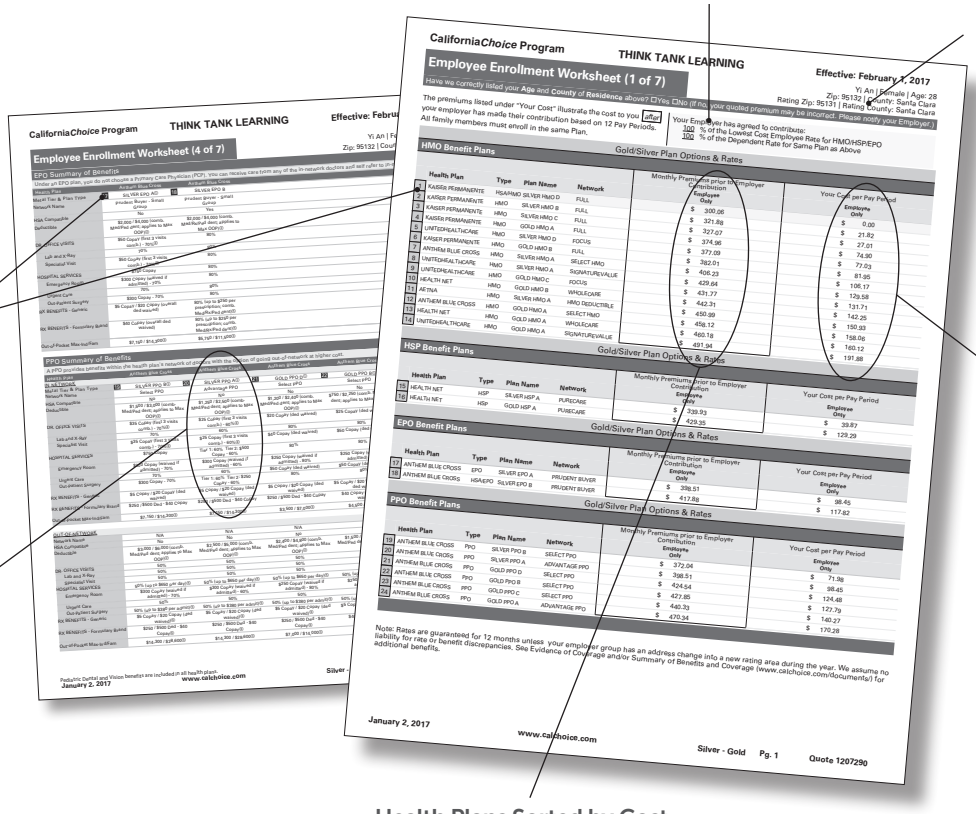
You can also see the costs associated with adding a spouse and/or dependents to your coverage.

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, HSP, 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 California*Choice* 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

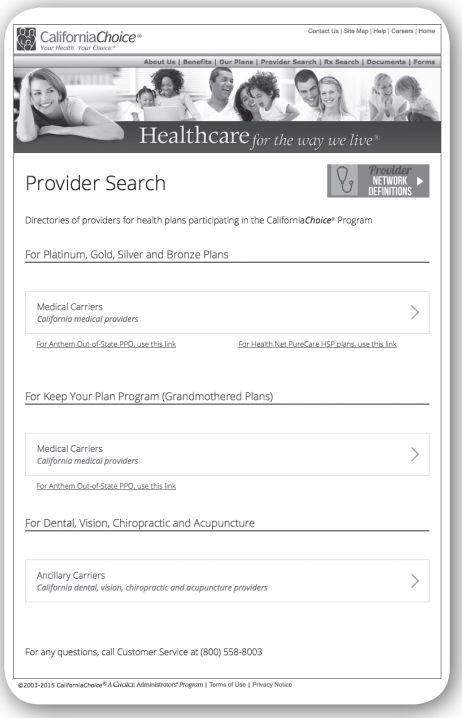
Whether you have a current doctor you would like to get care from, or you're looking for a new Primary Care Physician, California*Choice*® makes it easy to quickly look up doctors and specialists in the network for the health plan you select.

Our California*Choice* 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:

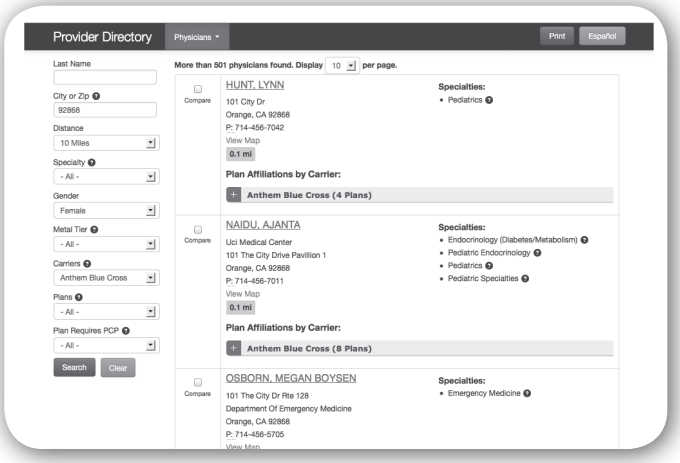
- Entering the last name of the doctor
- Selecting the distance from your city or ZIP Code entry
- Specifying a medical specialty
- Choosing your health plan Metal Tier
- Selecting "yes" or "no" on whether the plan requires a Primary Care Physician



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, **California*Choice* 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.

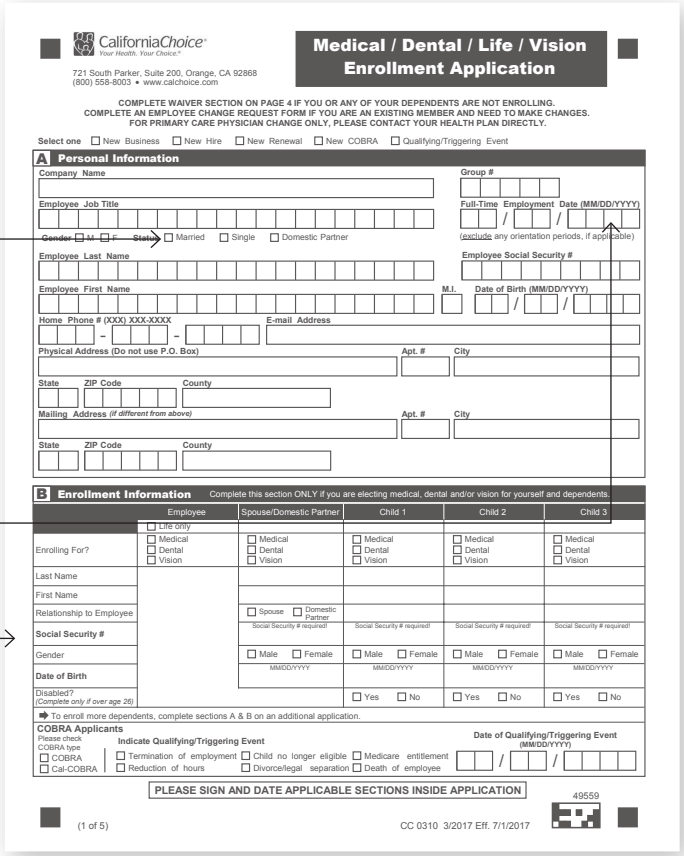
HOW TO ENROLL

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



CaliforniaChoice®
Your Health. Your Choice.®
721 South Parker, Suite 200, Orange, CA 92868
(800) 558-8003 • www.calchoice.com

Medical / Dental / Life / Vision Enrollment Application

COMPLETE WAIVER SECTION ON PAGE 4 IF YOU OR ANY OF YOUR DEPENDENTS ARE NOT ENROLLING.
COMPLETE AN EMPLOYEE CHANGE REQUEST FORM IF YOU ARE AN EXISTING MEMBER AND NEED TO MAKE CHANGES.
FOR PRIMARY CARE PHYSICIAN CHANGE ONLY, PLEASE CONTACT YOUR HEALTH PLAN DIRECTLY.

Select one ☐ New Business ☐ New Hire ☐ New Renewal ☐ New COBRA ☐ Qualifying/Triggering Event

A Personal Information

Company Name | Group #
Employee Job Title | Full-Time Employment Date (MM/DD/YYYY) (exclude any orientation periods, if applicable)
Gender ☐ M ☐ F Status ☐ Married ☐ Single ☐ Domestic Partner
Employee Last Name | Employee Social Security #
Employee First Name | M.I. | Date of Birth (MM/DD/YYYY)
Home Phone # (XXX) XXX-XXXX | E-mail Address
Physical Address (Do not use P.O. Box) | Apt. # | City
State | ZIP Code | County
Mailing Address *(if different from above)* | Apt. # | City
State | ZIP Code | County

B Enrollment Information Complete this section ONLY if you are electing medical, dental and/or vision for yourself and dependents.

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
	☐ Life only				
Enrolling For?	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision
Last Name					
First Name					
Relationship to Employee		☐ Spouse ☐ Domestic Partner			
Social Security #		Social Security # required!	Social Security # required!	Social Security # required!	Social Security # required!
Gender		☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Disabled? *(Complete only if over age 26)*			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

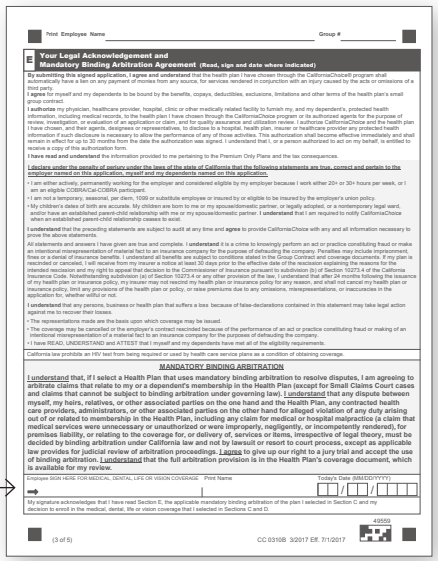
➡ To enroll more dependents, complete sections A & B on an additional application.

COBRA Applicants
Please check COBRA type: ☐ COBRA ☐ Cal-COBRA
Indicate Qualifying/Triggering Event: ☐ Termination of employment ☐ Child no longer eligible ☐ Medicare entitlement ☐ Reduction of hours ☐ Divorce/legal separation ☐ Death of employee
Date of Qualifying/Triggering Event (MM/DD/YYYY)

PLEASE SIGN AND DATE APPLICABLE SECTIONS INSIDE APPLICATION

49559

(1 of 5) CC 0310 3/2017 Eff. 7/1/2017



Print Employee Name _____ Group # _____

E Your Legal Acknowledgement and Mandatory Binding Arbitration Agreement (Read, sign and date where indicated)

By submitting this signed application, I agree and understand that the health plan I have chosen through the CaliforniaChoice® program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.
I agree for myself and my dependents to be bound by the benefits, copays, deductibles, exclusions, limitations and other terms of the health plan's small group contract.
I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the CaliforniaChoice program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize CaliforniaChoice and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.
I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.
I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application:
• I am either actively, permanently working for the employer and considered eligible by my employer because I work either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
• I am not a temporary, seasonal, per diem, 1099 or substitute employee or insured by or eligible to be insured by the employer's union policy.
• My children's dates of birth are accurate. My children are born to me or my spouse/domestic partner, or legally adopted, or a nonlegal legal ward, and/or have an established parent-child relationship with me or my spouse/domestic partner. **I understand** that I am required to notify CaliforniaChoice when an established parent-child relationship ceases to exist.
I understand that the preceding statements are subject to audit at any time and **agree** to provide CaliforniaChoice with any and all information necessary to prove the above statements.
All statements and answers I have given are true and complete. **I understand** it is a crime to knowingly perform an act or practice constituting fraud or make an intentional misrepresentation of material fact to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents. If my plan is rescinded or canceled, I will receive from my insurer a notice at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and my right to appeal that decision to the Commissioner of Insurance pursuant to subdivision (b) of Section 10273.4 of the California Insurance Code. Notwithstanding subdivision (a) of Section 10273.4 or any other provision of the law, I understand that after 24 months following the issuance of my health plan or insurance policy, my insurer may not rescind my health plan or insurance policy for any reason, and shall not cancel my health plan or insurance policy, limit any provisions of the health plan or policy, or raise premiums due to any omissions, misrepresentations, or inaccuracies in the application for, whether willful or not.
I understand that any persons, business or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.
• The representations made are the basis upon which coverage may be issued.
• The coverage may be cancelled or the employer's contract rescinded because of the performance of an act or practice constituting fraud or making of an intentional misrepresentation of a material fact to an insurance company for the purposes of defrauding the company.
• I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

MANDATORY BINDING ARBITRATION

I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the Health Plan's coverage document, which is available for my review.

Employee SIGN HERE FOR MEDICAL, DENTAL, LIFE OR VISION COVERAGE Print Name Today's Date (MM/DD/YYYY)
➡
My signature acknowledges that I have read Section E, the applicable mandatory binding arbitration of the plan I selected in Section C and my decision to enroll in the medical, dental, life or vision coverage that I selected in Sections C and D.

49559

(3 of 5) CC 0310B 3/2017 Eff. 7/1/2017

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 California*Choice*® 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 California*Choice* 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:

- Neither is married under either statutory, common law, or part of another domestic partnership
- Both be 18 years of age or older; or, if under 18, have a valid court order allowing partnership
- Share an intimate and committed relationship
- Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship
- Both be mentally competent
- Not related by blood to a degree of closeness that would prohibit marriage in this state
- Agree to notify California*Choice* immediately upon termination of domestic partnership

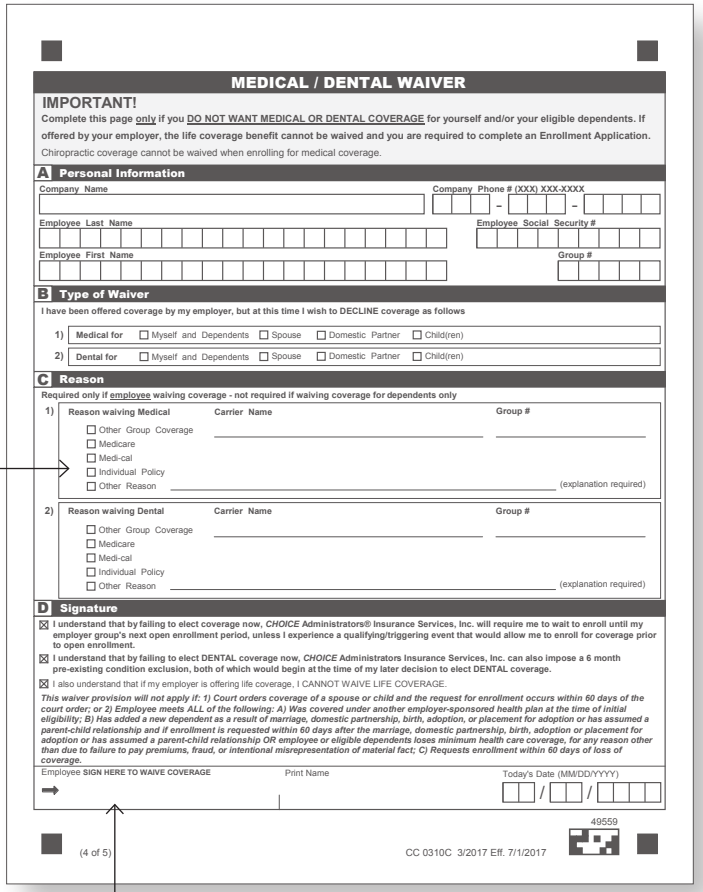
Members who are in a same sex partnership or are the opposite sex and over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 60 days of issue; all others must submit a signed Affidavit of Domestic Partnership.

Formal proof of the required eligibility and existence of the relationship of the dependent to the Subscriber may be requested at the time of enrollment, service authorization request, or claim submission.

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.



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) ☐☐/☐☐/☐☐☐☐

49559

(4 of 5) CC 0310C 3/2017 Eff. 7/1/2017

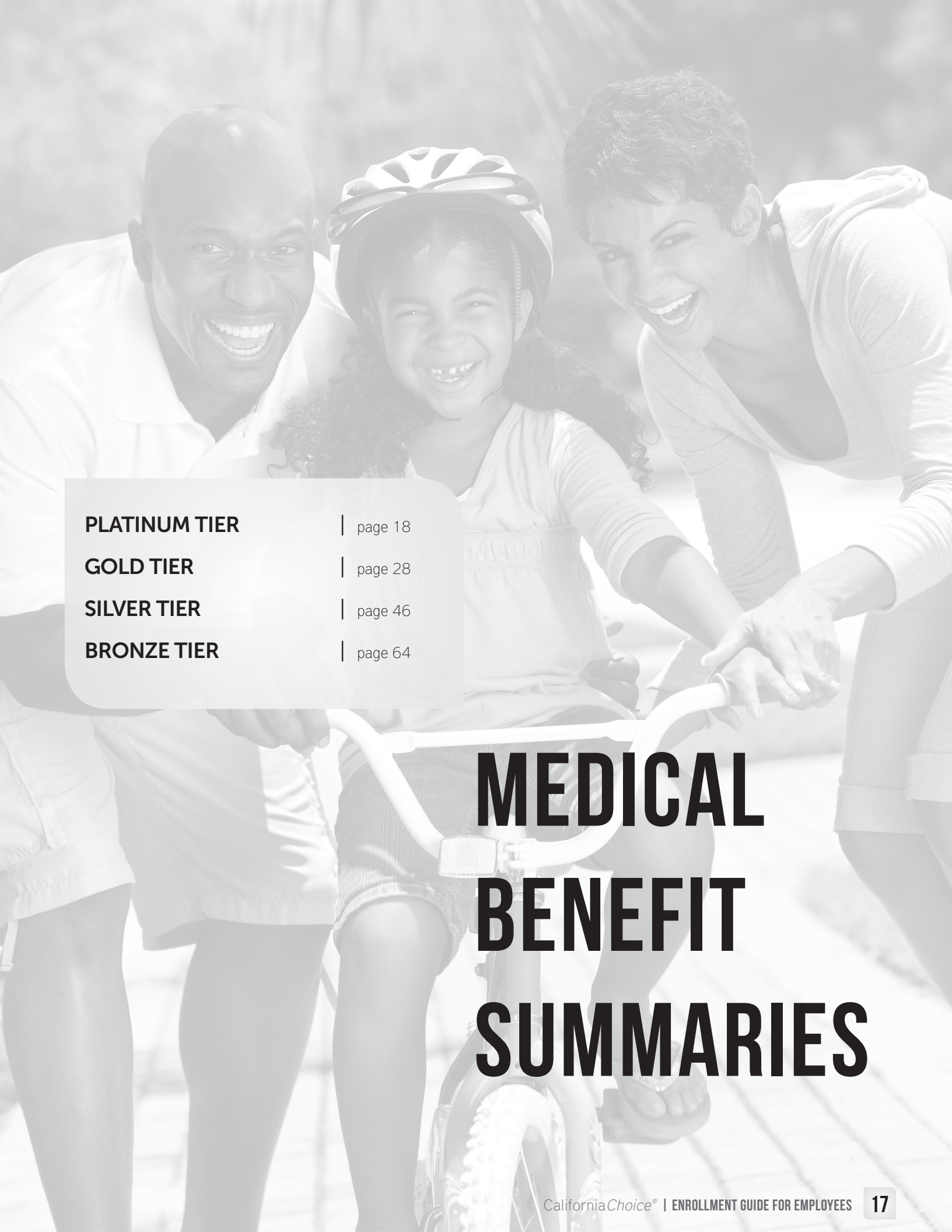
REMEMBER TO:

Check-off the correct reason for waiving coverage

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 10/1/17

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

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

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

1. Must be medically necessary.
2. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
3. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
4. See plan specific EOC for information on preventive services.
5. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
6. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.
10. Pediatric dental and vision are included on all plans.
11. Limited to 100 4-hour visits per benefit period.
12. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
13. Evaluation only.
14. Maximum member responsibility.
15. Medical emergency only.
16. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
17. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
18. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
19. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
20. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Platinum HMO

Groups Beginning 10/1/17

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

Platinum HMO

Groups Beginning 10/1/17

Services	HMO A	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 5 days max	$200 Copay	85%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	90% [6]	50%	50%
Mental Health			
In-Patient	$300 Copay per day – 5 days max	$400 Copay	85%
Out-Patient (office visit)	$10 Copay	$15 Copay	$15 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$300 Copay per day – 5 days max	$400 Copay	85%
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%	100%	100%
Contact Lenses	1 pair per calendar year	1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses
Frames	1 pair per calendar year	100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Premier Access	Premier Access
Network	DeltaCare USA	Access Dental DHMO	Access Dental DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$1,000 / $2,000 [7]	$1,000 / $2,000 [7]
Office Visit	100%	$20 Copay	$20 Copay
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	$40 Copay [2]	$95 Copay [2]	$95 Copay [2]
Major Services (no waiting period)	$365 Copay [3]	$365 Copay [3]	$365 Copay [3]
Orthodontics (medically necessary)	$350 Copay	$1,000 Copay	$1,000 Copay

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
5. See plan specific EOC for information on preventive services.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
8. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
9. Maximum member responsibility.

Platinum HMO

Groups Beginning 10/1/17

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

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay	$150 Copay per day – 5 days max	90%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	90%	90%
Mental Health			
In-Patient	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max [9]	$250 Copay per day – 5 days max [9]
Out-Patient (office visit)	$10 Copay	$15 Copay [10]	$25 Copay [10]
Drug/Substance Abuse			
In-Patient (Detox Only)	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max [9]	$250 Copay per day – 5 days max [9]
Infertility			
Infertility Evaluation and Treatment	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% [5, 6]	100% [5, 6]
Maximum Allowance per year	None	1 pair per year	1 pair per year
Pediatric Dental			
Carrier	Premier Access	Delta Dental	Delta Dental
Network	Access Dental DHMO	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$1,000/$2,000 [13]	Combined with Medical	Combined with Medical
Office Visit	$20 Copay	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	$95 Copay [14]	$25 Copay	$25 Copay
Major Services (no waiting period)	$365 Copay [15]	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. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
2. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
3. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
4. See plan specific EOC for information on preventive services.
5. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
6. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
7. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
8. Maximum member responsibility.
9. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
10. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.
11. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
12. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum
13. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
14. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
15. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.

Platinum HMO

Groups Beginning 10/1/17

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

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

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

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

Platinum HMO

Groups Beginning 10/1/17

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

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

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

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

Gold HMO

Groups Beginning 10/1/17

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

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

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

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

Gold HMO & HSP

Groups Beginning 10/1/17

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

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

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

1. Must be medically necessary.
2. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
3. See plan specific EOC for information on preventive services.
4. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
5. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
6. The brand-name prescription drug deductible (per member, per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Pediatric dental and vision are included on all plans.
10. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
11. Maximum member responsibility.

Gold HMO

Groups Beginning 10/1/17

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

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

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
5. See plan specific EOC for information on preventive services.
6. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
7. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
8. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
9. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
10. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
11. Maximum member responsibility.

Gold HMO

Groups Beginning 10/1/17

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

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

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

1. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
2. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. In high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or $2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
8. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
9. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
10. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
11. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
12. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.

(Foot notes continued on page 78)

Gold HMO

Groups Beginning 10/1/17

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

Services	HMO B	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max	70%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80%	$50 Copay	$50 Copay
Mental Health			
In-Patient	$600 Copay per day – 5 days max [13]	70%	70%
Out-Patient (office visit)	$30 Copay [14]	$50 Copay	$50 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day – 5 days max [13]	70%	70%
Infertility			
Infertility Evaluation and Treatment	Not Covered	50%	50%
Infertility Drugs	Not Covered	See Plan Specific EOC	See Plan Specific EOC
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	50% [5]	50% [5]
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% [11]	100%	100%
Contact Lenses	100% (in lieu of eyeglasses) [11, 12]	70%	70%
Frames	100% [11, 12]	70%	70%
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	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	$25 Copay	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. See plan specific EOC for information on preventive services.
2. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. For Specialty drugs, please see plan specific EOC.
4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
6. Maximum member responsibility.
7. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
8. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
9. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
10. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
11. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
12. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
13. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
14. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.

Gold HMO

Groups Beginning 10/1/17

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

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

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

1. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
2. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
3. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
4. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
7. For Specialty drugs, please see plan specific EOC.
8. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
9. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
10. Maximum member responsibility.
11. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
12. Copayments do not contribute to out-of-pocket maximum.
13. Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.

Gold HMO

Groups Beginning 10/1/17

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

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

† HSA Qualified High Deductible Plan

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

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

Gold PPO

Groups Beginning 10/1/17

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

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

(Foot notes continued on page 78)

Gold PPO

Groups Beginning 10/1/17

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

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

(Foot notes continued on page 78)

Silver HMO

Groups Beginning 10/1/17

Services	HMO A
Participating Health Plans	Anthem Blue Cross
Network Name	Select HMO
Metal Tier	**Silver**
Calendar Year Deductible*	$1,750 / $3,500 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300 [3]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived)
Specialist Visit (SPC)	$75 Copay (ded waived)
Laboratory	$25 Copay (ded waived)
X-Ray	$25 Copay (ded waived)
MRI, CT and PET (office setting)	$75 Copay per test (ded waived) [14]
Hospital Services – In-Patient	60%
In-Patient Physician Fees	100% (ded waived)
Emergency Room (copay waived if admitted)	$300 Copay – 60%
Urgent Care	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%
Hospital Pre-Authorization	Required
2nd Surgical Opinion	$75 Copay (ded waived)
Ambulance Services (per trip)	60% [8]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay / $20 Copay (ded waived) [9] $250 / $500 Ded – $50 Copay [9] $250 / $500 Ded – $90 Copay [9] $250 / $500 Ded – 70% (up to $250 per prescription [7]) (prior auth. required) [5, 9]
Oral Contraceptives	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [9]
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	60% (ded waived) [10]
Chiropractic (20 visits max per year)	$50 Copay (ded waived) (20 visits max per benefit period) [11]
Acupuncture	$50 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [12]
Home Health Care (Max 100 visits per year)	$50 Copay (ded waived) (Max visits per benefit period) [4]

Services	HMO A
Participating Health Plans	Anthem Blue Cross
Network Name	Select HMO
Metal Tier	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% [13]
Hospice	100%
Durable Medical Equipment (Covered when medically necessary)	50%
Mental Health In-Patient Out-Patient (office visit)	 60% $50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%
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
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
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% (ded waived) 50% 50% 50%

* 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, but no one member is required to meet his/her individual 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, but no one Member is required to meet his/her individual 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 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
10. 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.

Silver HMO & HSP

Groups Beginning 10/1/17

Services	HSP A	HMO B	HMO C
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,750 / $3,500 (applies to Max OOP)	$1,000 / $2,000[6] (applies to Max OOP)	$1,500 / $3,000[6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300	$6,500 / $13,000[7]	$6,800 / $13,600[7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay[4]	$45 Copay (ded waived)	$50 Copay (ded waived)
Specialist Visit (SPC)	$45 Copay[4]	$45 Copay (ded waived)	$50 Copay (ded waived)
Laboratory	$35 Copay	$45 Copay (ded waived)	$30 Copay (ded waived)
X-Ray	$35 Copay	$50 Copay (ded waived)	$50 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay per procedure	$250 Copay per procedure	$250 Copay per procedure
Hospital Services – In-Patient	50%	70%	80%
In-Patient Physician Fees	50%	70%	80%
Emergency Room (copay waived if admitted)	50%	70%	$300 Copay
Urgent Care	$45 Copay	$45 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 50% 50%	 70% 70%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$45 Copay	70%	80%
Ambulance Services (per trip)	50%	70%	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay (overall ded waived) $30 Copay (overall ded waived) 50% (up to $250 per prescription[12]) (overall ded waived) 50% (up to $250 per prescription[12]) (overall ded waived)	 $25 Copay (ded waived) $150 Ded – $60 Copay $150 Ded – $60 Copay (with physician approval) $150 Ded – 80% (up to $250 per prescription[12]) (with physician approval)	 $20 Copay (ded waived) $200 Ded – $50 Copay $200 Ded – $50 Copay (with physician approval) $200 Ded – 80% (up to $250 per prescription[12]) (with physician approval)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	50% (overall ded waived)	$150 Ded – $60 Copay	$200 Ded – $50 Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[5]	100% (ded waived)[5]	100% (ded waived)[5]
Chronic Disease Management	$45 Copay	$40 Copay	80%
Chemotherapy	50%	100% (ded waived)	100% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay	$45 Copay (ded waived)	$50 Copay (ded waived)
Physical, Occupational, Speech Therapy	$30 Copay	$45 Copay (ded waived)	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$30 Copay	$45 Copay (ded waived)	$50 Copay (ded waived)
Home Health Care (Max 100 visits per year)	50%	100% (ded waived)[1]	100% (ded waived)[1]

Services	HSP A	HMO B	HMO C
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50% (no limit)	70%	80%
Hospice	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	70% (ded waived) [8]	80% (ded waived) [8]
Mental Health In-Patient Out-Patient (office visit)	 50% $30 Copay	 70% $45 Copay (ded waived)	 80% $50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 50%	 70%	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% [9] 50% [9] Not Covered 50% [9] Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [10] EyeMed 100% 100% 1 pair per calendar year None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 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% 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) $95 Copay [2] $365 Copay [3] $350 Copay	 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. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
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. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
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.

Silver HMO

Groups Beginning 10/1/17

Services	HMO D† HSA Qualified	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,350 / $2,600 / $2,700[7] (combined Med/Rx ded) (applies to Max OOP)	$1,800 / $3,600[2] (applies to Max OOP)	$1,800 / $3,600[2] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,450 / $12,900[8]	$6,000 / $12,000[2]	$6,250 / $12,500[2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	70%	$30 Copay (ded waived)	$35 Copay (ded waived)
Specialist Visit (SPC)	70%	$60 Copay (ded waived)	$70 Copay (ded waived)
Laboratory	70%	$30 Copay	$15 Copay
X-Ray	70%	$60 Copay	$30 Copay
MRI, CT and PET (office setting)	70%	$250 Copay per procedure	$300 Copay per procedure
Hospital Services – In-Patient	70%	$750 Copay per day	70%
In-Patient Physician Fees	70%	100%	70%
Emergency Room (copay waived if admitted)	70%	$250 Copay	70%
Urgent Care	70%	$60 Copay (ded waived)	$70 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	70%	$60 Copay (ded waived)	$70 Copay (ded waived)
Ambulance Services (per trip)	70%	$250 Copay (ded waived)	70% (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 70% (up to $250 per prescription[9]) (combined Med/Rx ded) 70% (up to $250 per prescription[9]) (combined Med/Rx ded) 70% (up to $250 per prescription[9]) (combined Med/Rx ded) (with physician approval) 70% (up to $250 per prescription[9]) (combined Med/Rx ded) (with physician approval)	 $19 Copay (ded waived) $200 / $400 Ded – $50 Copay $200 / $400 Ded – $80 Copay $200 / $400 Ded – Applicable Rx Copay	 $19 Copay (ded waived) $200 / $400 Ded – $50 Copay $200 / $400 Ded – $100 Copay $200 / $400 Ded – Applicable Rx Copay
Oral Contraceptives	100%	100% (if in formulary)	100% (if in formulary)
Diabetes – Self-Injectable	70% (up to $250 per prescription[9]) (combined Med/Rx ded)	$200 / $400 Ded – Applicable Rx Copay	$200 / $400 Ded – Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[1]	100% (ded waived)[1]	100% (ded waived)[1]
Chronic Disease Management	70%	$60 Copay (ded waived)	$70 Copay (ded waived)
Chemotherapy	70%	Variable[6]	Variable[6]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	70%	$30 Copay (ded waived)	$35 Copay (ded waived)
Physical, Occupational, Speech Therapy	70%	$30 Copay (ded waived)	$35 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	70%	$30 Copay (ded waived)	$35 Copay (ded waived)

Services	HMO D† HSA Qualified	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	100%[10]	$30 Copay (ded waived)	$35 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	$200 Copay per day	70%
Hospice	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	70%	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 70% 70%	 $750 Copay per day $30 Copay (ded waived)	 70% $35 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 70%	 $750 Copay per day	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay[4] $365 Copay[5] $350 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000[3] $20 Copay 100% $95 Copay[4] $365 Copay[5] $1,000 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000[3] $20 Copay 100% $95 Copay[4] $365 Copay[5] $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. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
3. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
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. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. $1,350 Self only enrollment, $2,600 for any one member within a Family enrollment. $2,700 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).

Silver HMO

Groups Beginning 10/1/17

Services	HMO C	HMO B	HMO C† HSA Qualified
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [13] (applies to Max OOP)	$2,000 / $4,000 [1] (applies to Max OOP)	$2,000 / $2,600 / $4,000 [1, 10] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700 [13, 14]	$6,800 / $13,600 [2]	$5,400 / $10,800 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$45 Copay (ded waived) [8]	$35 Copay [8]
Specialist Visit (SPC)	$70 Copay (ded waived)	$75 Copay (ded waived)	$35 Copay
Laboratory	$50 Copay	$40 Copay (ded waived)	$35 Copay
X-Ray	$50 Copay	$70 Copay (ded waived)	$15 Copay
MRI, CT and PET (office setting)	$500 Copay per procedure	$300 Copay (ded waived)	$50 Copay
Hospital Services – In-Patient	50%	80%	80%
In-Patient Physician Fees	50%	80%	80%
Emergency Room (copay waived if admitted)	50%	$350 Copay (ded waived)	80%
Urgent Care	$70 Copay (ded waived)	$45 Copay (ded waived)	$35 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 50% 50%	 80% (ded waived) 80% (ded waived)	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$70 Copay (ded waived)	$75 Copay (ded waived)	$35 Copay
Ambulance Services (per trip)	50% (ded waived)	$250 Copay (ded waived)	80%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (overall ded waived) $50 Copay (overall ded waived) $100 Copay (overall ded waived) Applicable Rx Copay (overall ded waived)	 $15 Copay (ded waived) [3] $250 / $500 Ded – $55 Copay [3, 4] $250 / $500 Ded – $85 Copay [3, 4] $250 / $500 Ded – 80% (up to $250 per prescription [9]) [3, 4]	 $10 Copay (combined Med/Rx ded) [3] $20 Copay (combined Med/Rx ded) [3, 4] $40 Copay (combined Med/Rx ded) [3, 4] 80% (up to $250 per prescription [9]) (combined Med/Rx ded) [3, 4]
Oral Contraceptives	100% (overall ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived)	$250 / $500 Ded – Applicable Rx Copay [3, 4]	Applicable Rx Copay (combined Med/Rx ded) [3, 4]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	$70 Copay (ded waived)	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [15]	80% (ded waived)	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$40 Copay (ded waived)	$45 Copay (ded waived)	$35 Copay
Physical, Occupational, Speech Therapy	$40 Copay (ded waived)	$45 Copay (ded waived)	$35 Copay
Rehabilitative & Habilitative Services and Devices	$40 Copay (ded waived)	$45 Copay (ded waived)	$35 Copay
Home Health Care (Max 100 visits per year)	$40 Copay (ded waived)	$45 Copay (ded waived)	80%

Services	HMO C	HMO B	HMO C† HSA Qualified
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50%	80%	80%
Hospice	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	50%	80% (ded waived)	80%
Mental Health			
In-Patient	50%	80% [11]	80% [11]
Out-Patient (office visit)	$40 Copay (ded waived)	$45 Copay (ded waived) [12]	$35 Copay [12]
Drug/Substance Abuse			
In-Patient (Detox Only)	50%	80% [11]	80% [11]
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% (ded waived) [6]	100% (ded waived) [6]
Contact Lenses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses; ded waived) [6, 7]	100% (in lieu of eyeglasses; ded waived) [6, 7]
Frames	100% (Pediatric Exchange collection only)	100% (ded waived) [6, 7]	100% (ded waived) [6, 7]
Maximum Allowance per year	None	1 pair per year	1 pair per year
Pediatric Dental			
Carrier	Premier Access	Delta Dental	Delta Dental
Network	Access Dental DHMO	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$1,000 / $2,000 [16]	Combined with Medical	Combined with Medical
Office Visit	$20 Copay	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100%	100% (ded waived)	100% (ded waived)
Basic Services	$95 Copay [17]	$25 Copay (ded waived)	$25 Copay (ded waived)
Major Services (no waiting period)	$365 Copay [18]	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay (ded waived)	$1,000 Copay (ded waived)

† HSA Qualified High Deductible Plan

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

1. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or $2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
2. Cost sharing amounts for all essential health benefits, including those applied to deductible, accumulate toward the out-of-pocket maximum.
3. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
4. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
8. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
9. Maximum member responsibility.
10. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
11. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
12. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.

(Foot notes continued on page 78)

Silver HMO

Groups Beginning 10/1/17

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [5] (applies to Max OOP)	$2,000 / $4,000 [5] (applies to Max OOP)	$2,000 / $4,000 [8] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [6]	$6,750 / $13,500 [6]	$6,750 / $13,500 [9]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay (ded waived)	$45 Copay (ded waived)	70%
Specialist Visit (SPC)	$65 Copay (ded waived)	$65 Copay (ded waived)	70%
Laboratory	$25 Copay (ded waived)	$25 Copay (ded waived)	70%
X-Ray	$25 Copay (ded waived)	$25 Copay (ded waived)	70%
MRI, CT and PET (office setting)	$200 Copay per procedure (ded waived)	$200 Copay per procedure (ded waived)	70%
Hospital Services – In-Patient	60%	60%	70%
In-Patient Physician Fees	60% (ded waived)	60% (ded waived)	70% (ded waived)
Emergency Room (copay waived if admitted)	$400 Copay (ded waived)	$400 Copay (ded waived)	70%
Urgent Care	$100 Copay (ded waived)	$100 Copay (ded waived)	70%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$65 Copay (ded waived)	$65 Copay (ded waived)	70%
Ambulance Services (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	70%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $200 / $400 Ded – $50 Copay [2] $200 / $400 Ded – $100 Copay [2] $200 / $400 Ded – 75% (up to $250 per prescription [4]) [2]	 $20 Copay (ded waived) $200 / $400 Ded – $50 Copay [2] $200 / $400 Ded – $100 Copay [2] $200 / $400 Ded – 75% (up to $250 per prescription [4]) [2]	 $20 Copay (ded waived) $200 / $400 Ded – $50 Copay [2] $200 / $400 Ded – $100 Copay [2] $200 / $400 Ded – 75% (up to $250 per prescription [4]) [2]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$200 / $400 Ded – Applicable Rx Copay [2]	$200 / $400 Ded – Applicable Rx Copay [2]	$200 / $400 Ded – Applicable 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	$150 Copay (ded waived) [7]	$150 Copay (ded waived) [7]	70%
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay (ded waived)	70%
Acupuncture	$10 Copay (ded waived)	$10 Copay (ded waived)	70%
Physical, Occupational, Speech Therapy	$45 Copay (ded waived)	$45 Copay (ded waived)	70%
Rehabilitative & Habilitative Services and Devices	$45 Copay (ded waived)	$45 Copay (ded waived)	70%
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	$45 Copay (ded waived)	70%

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	70%
Hospice	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	$50 Copay (ded waived)	$50 Copay (ded waived)	70%
Mental Health In-Patient Out-Patient (office visit)	 60% $65 Copay (ded waived)	 60% $65 Copay (ded waived)	 70% 70%
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 60%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) [3] Not Covered	 50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) [3] Not Covered	 50% See Plan Specific EOC Not Covered 50% [3] 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) 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
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. For Specialty drugs, please see plan specific EOC.
3. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
4. Maximum member responsibility.
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 (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
7. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
8. The Family Deductible is a non-embedded deductible. One or more eligible members of a family unit may satisfy the entire Family Deductible. No one in the family will be eligible for benefits until the Family Deductible has been satisfied.
9. When more than one person in a family is covered under the Health Plan, the Individual Out-of-Pocket Maximum does not apply. Copayments for Covered Services will continue to be required from every eligible member of the family until the Family Out-of-Pocket Maximum has been met. No further Copayments will be required for Covered Services (except infertility services) for the Calendar Year from any eligible family member once the Family Out-of-Pocket Maximum has been satisfied.

Silver HMO

Groups Beginning 10/1/17

Services	HMO D	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [11] (applies to Max OOP)	$1,750 / $3,500 [1, 14] (applies to Max OOP)	$2,000 / $4,000 [1, 14] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [12]	$6,750 / $13,500 [2, 14]	$6,800 / $13,600 [2, 14]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Specialist Visit (SPC)	$65 Copay (ded waived)	$50 Copay (ded waived)	$75 Copay (ded waived)
Laboratory	$25 Copay (ded waived)	$50 Copay (ded waived)	$40 Copay (ded waived)
X-Ray	$25 Copay (ded waived)	$50 Copay (ded waived)	$70 Copay (ded waived)
MRI, CT and PET (office setting)	$200 Copay per procedure (ded waived)	$300 Copay (ded waived)	$300 Copay (ded waived)
Hospital Services – In-Patient	60%	80% [1, 4]	80% [1, 4]
In-Patient Physician Fees	60% (ded waived)	100% (ded waived)	80% [1, 4]
Emergency Room (copay waived if admitted)	$400 Copay (ded waived)	70% [1, 4]	$350 Copay (ded waived)
Urgent Care	$100 Copay (ded waived)	$100 Copay [1]	$45 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 80% [1, 4] 80% [1, 4]	 80% (ded waived) [4] 80% (ded waived) [4]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$65 Copay (ded waived)	$50 Copay (ded waived)	$70 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	100% (ded waived)	$250 Copay [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $200 / $400 Ded – $50 Copay [9] $200 / $400 Ded – $100 Copay [9] $200 / $400 Ded – 75% (up to $250 per prescription [8]) [9]	 $20 Copay (ded waived) $250 / $500 Ded – $55 Copay [1, 16] $250 / $500 Ded – $75 Copay [1, 16] $250 / $500 Ded – 80% (up to $250 per 30 day supply [8]) [1, 4]	 $15 Copay (ded waived) $250 / $500 Ded – $55 Copay [1, 16] $250 / $500 Ded – $85 Copay [1, 16] $250 / $500 Ded – 80% (up to $250 per 30 day supply [8]) [1, 4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$200 / $400 Ded – Applicable Rx Copay [9]	$250 / $500 Ded – $50 Copay [1]	$250 / $500 Ded – $55 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% (ded waived) [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	$150 Copay (ded waived) [13]	100% (ded waived)	80% [1, 4]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay (ded waived) [15]	$15 Copay (ded waived) [15]
Acupuncture	$10 Copay (ded waived)	$15 Copay (ded waived)	$45 Copay (ded waived)
Physical, Occupational, Speech Therapy	$45 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$45 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	100% (ded waived)	$45 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	80% [1, 4]	80% [1, 4]

Services	HMO D	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Hospice	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$50 Copay (ded waived)	80% (ded waived) [4, 5]	80% (ded waived) [4, 5]
Mental Health In-Patient Out-Patient (office visit)	 60% $65 Copay (ded waived)	 80% [1, 4] $50 Copay (ded waived)	 80% [1, 4] $45 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 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)	 50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) [10] 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	 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)	 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	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. 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 soft contact lenses instead of glasses.
8. Maximum member responsibility.
9. For Specialty drugs, please see plan specific EOC.
10. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
11. 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.
12. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
13. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
14. 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.
15. Copayments do not contribute to out-of-pocket maximum.
16. 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.

Silver HMO

Groups Beginning 10/1/17

Services	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Silver**
Calendar Year Deductible*	$2,000 / $2,600 / $4,000 [1, 9, 10] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,550 / $13,100 [2, 10]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	80% [1, 4]
Specialist Visit (SPC)	80% [1, 4]
Laboratory	80% [1, 4]
X-Ray	80% [1, 4]
MRI, CT and PET (office setting)	80% [1, 4]
Hospital Services – In-Patient	80% [1, 4]
In-Patient Physician Fees	80% [1, 4]
Emergency Room (copay waived if admitted)	80% [1, 4]
Urgent Care	80% [1, 4]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% [1, 4] 80% [1, 4]
Hospital Pre-Authorization	Required
2nd Surgical Opinion	80% [1, 4]
Ambulance Services (per trip)	80% [1, 4]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 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)
Diabetes – Self-Injectable	80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness
Chemotherapy	80% [1, 4]
Chiropractic (20 visits max per year)	Not Covered
Acupuncture	80% [1, 4]
Physical, Occupational, Speech Therapy	80% [1, 4]
Rehabilitative & Habilitative Services and Devices	80% [1, 4]

Services	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Silver**
Home Health Care (Max 100 visits per year)	80% [1, 4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% [1, 4]
Hospice	100% [1]
Durable Medical Equipment (Covered when medically necessary)	80% [1, 4, 5]
Mental Health In-Patient Out-Patient (office visit)	 80% [1, 4] 80% [1, 4]
Drug/Substance Abuse In-Patient (Detox Only)	 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
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]
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 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.

Silver PPO

Groups Beginning 10/1/17

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [10]	In-Network	Out-of-Network [10]
Calendar Year Deductible*	$1,250 / $2,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,500 / $5,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,500 / $3,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,000 / $6,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300 [1]	$14,300 / $28,600 [1]	$7,150 / $14,300 [1]	$14,300 / $28,600 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$25 Copay (first 3 visits) [9] – 60%	50%	$35 Copay (first 3 visits) [9] – 70%	50%
Specialist Visit (SPC)	$25 Copay (first 3 visits) [9] – 60%	50%	$35 Copay (first 3 visits) [9] – 70%	50%
Laboratory	60%	50%	70%	50%
X-Ray	60%	50%	70%	50%
MRI, CT and PET (office setting)	60% [15]	50% (up to $800 per test) [5, 15]	70% [15]	50% (up to $800 per test) [5, 15]
Hospital Services – In-Patient	Tier 1: 60% Tier 2: $500 Copay per admit – 60%	50% (up to $650 per day) [5]	$750 Copay per admit	50% (up to $650 per day) [5]
In-Patient Physician Fees	60%	50%	70%	50%
Emergency Room (copay waived if admitted)	$300 Copay – 60%		$300 Copay – 70%	
Urgent Care	60%	50%	70%	50%
Hospital Services – Out-Patient				
Surgical Facility	Tier 1: 60% Tier 2: $250 Copay per admit – 60%	50% (up to $380 per admit) [5]	$300 Copay per admit – 70%	50% (up to $380 per admit) [5]
Ambulatory Surgery Center	Tier 1: 60% Tier 2: $250 Copay per admit – 60%	50% (up to $380 per admit) [5]	$300 Copay per admit – 70%	50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Required		Required	
2nd Surgical Opinion	$25 Copay (first 3 visits) [9] – 60%	50%	$35 Copay (first 3 visits) [9] – 70%	50%
Ambulance Services (per trip)	60% [14]		70% [14]	
Rx Benefits				
Generic	$5 Copay / $20 Copay (ded waived) [2]	Not Covered	$5 Copay / $20 Copay (ded waived) [2]	Not Covered
Formulary Brand	$250 / $500 Ded - $40 Copay [2]	Not Covered	$250 / $500 Ded – $40 Copay [2]	Not Covered
Non-Formulary Brand	$250 / $500 Ded - $80 Copay [2]	Not Covered	$250 / $500 Ded – $80 Copay [2]	Not Covered
Specialty	$250 / $500 Ded - 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	Not Covered	$250 / $500 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable 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%	70%	50%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	Not Covered	50% (ded waived) (20 visits max per benefit period) [11]	Not Covered
Acupuncture	60%	Not Covered	70%	Not Covered
Physical, Occupational, Speech Therapy	60%	50%	70%	50%

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 [10]	In-Network	Out-of-Network [10]
Rehabilitative & Habilitative Services and Devices	60% [12]	50% [12]	70% [12]	50% [12]
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]	70% (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% [13] Tier 2: $500 Copay per admit – 60% [13]	50% (up to $150 per day) [5, 13]	$750 Copay per admit [13]	50% (up to $150 per day) [5, 13]
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%	50%
Mental Health				
In-Patient	Tier 1: 60% Tier 2: $500 Copay per admit – 60%	50% (up to $650 per day) [5]	$750 Copay per admit	50% (up to $650 per day) [5]
Out-Patient (office visit)	$25 Copay (first 3 visits) [9] – 60%	50%	$35 Copay (first 3 visits) [9] – 70%	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]	$750 Copay per admit	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	$25 Copay (first 3 visits) [9] – 60% [7]	50% [7]	$35 Copay (first 3 visits) [9] – 70% [7]	50% [7]
Infertility Drugs	Not Covered	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision				
Carrier	Anthem Vision	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision		Blue View Vision	
Exam	100% (ded waived)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	100% (ded waived)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Contact Lenses	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)
Frames	100% (ded waived) (1 per calendar year)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year)	100% (ded waived) (1 per calendar year)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental				
Carrier	Anthem Dental	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime		Prime	
Deductible	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	50%	50%	50%	50%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

(Foot notes continued on page 79)

Silver EPO

Groups Beginning 10/1/17

Services	EPO A	EPO B † HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer - Small Group	Prudent Buyer – Small Group
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [2] (combined Med/Pediatric dental ded)(applies to Max OOP)	$2,000 / $2,600 / $4,000 [10] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300 [3]	$5,750 / $11,500 [3]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (first 3 visits) [8] – 70%	80%
Specialist Visit (SPC)	$50 Copay (first 3 visits) [8] – 70%	80%
Laboratory	70%	80%
X-Ray	70%	80%
MRI, CT and PET (office setting)	70% [15]	80% [15]
Hospital Services – In-Patient	$750 Copay per admit	80%
In-Patient Physician Fees	70%	80%
Emergency Room (copay waived if admitted)	$300 Copay – 70%	80%
Urgent Care	70%	80%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay per admit – 70% $300 Copay per admit – 70%	 80% 80%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$50 Copay (first 3 visits) [8] – 70%	80%
Ambulance Services (per trip)	70% [9]	80% [9]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay / $20 Copay (overall ded waived) [11] $40 Copay (overall ded waived) [11] $80 Copay (overall ded waived) [11] 70% (up to $250 per prescription [7]) (overall ded waived) (prior auth. required) [5, 11]	 80% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [11] 80% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [11] 80% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [11] 80% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) (prior auth. required) [5, 11]
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) [11]	80% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [11]
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	70%	80%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [12]	50% (20 visits max per benefit period) [12]
Acupuncture	70%	80%
Physical, Occupational, Speech Therapy	70%	80%

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	70% [13]	80% [13]
Home Health Care (Max 100 visits per year)	70% (Max 100 visits per benefit period) [4]	80% (Max 100 visits per benefit period) [4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$750 Copay per admit [14]	80% [14]
Hospice	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%
Mental Health		
In-Patient	$750 Copay per admit	80%
Out-Patient (office setting)	$50 Copay (first 3 visits) [8] – 70%	80%
Drug/Substance Abuse		
In-Patient (Detox Only)	$750 Copay per admit	80%
Infertility		
Infertility Evaluation and Treatment	$50 Copay (first 3 visits) [8] – 70% [6]	80% [6]
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	Anthem Vision	Anthem Vision
Network	Blue View Vision	Blue View Vision
Exam	100% (ded waived)	100% (ded waived)
Contact Lenses	1 pair per calendar year	100% (in lieu of eyeglasses)
Frames	1 pair per calendar year (ded waived)	100% (ded waived)
Maximum Allowance per year	1 per calendar year	1 pair per calendar year
Pediatric Dental		
Carrier	Anthem Dental	Anthem Dental
Network	Prime	Prime
Deductible	Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Office Visit	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)
Basic Services	50%	50%
Major Services (no waiting period)	50%	50%
Orthodontics (medically necessary)	50%	50%

† HSA Qualified High Deductible Plan

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

1. 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, but no one member is required to meet his/her individual 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, but no one Member is required to meet his/her individual 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. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
9. Medical emergency only.
10. 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: $2,600 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 per family deductible is met. The per family deductible can be met by any combination of amounts from any member, but no one member is required to meet his/her per member deductible.
11. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
12. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
13. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
14. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
15. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Bronze HSP

Groups Beginning 10/1/17

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

Services	HSP A
Participating Health Plans	Health Net
Network Name	PureCare
Metal Tier	**Bronze**
Home Health Care (Max 100 visits per year)	50%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50% (no limit)
Hospice	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%
Mental Health In-Patient Out-Patient (office visit)	 50% $45 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 50%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% [2] 50% [2] Not Covered 50% [2] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [3] 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 [3, 5] Dental Benefit Providers None None 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. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
2. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
3. Pediatric dental and vision are included on all plans.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.

6 . Maximum member responsibility.

Bronze HMO

Groups Beginning 10/1/17

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

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

† HSA Qualified High Deductible Plan

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
5. See plan specific EOC information on preventive services.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
8. Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
9. Maximum member responsibility.
10. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
11. Under a family contract, an insured can satisfy their individual out-of-pocket maximum, however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
12. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

Bronze HMO

Groups Beginning 10/1/17

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

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

† HSA Qualified High Deductible Plan

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

1. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or $2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
2. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
3. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
4. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
8. Deductible is waived for the first three non-preventive visits (combined for primary care, specialist, urgent care, acupuncture and outpatient mental health).
9. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
10. In high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of Pocket Maximum.

(Foot notes continued on page 79)

Bronze HMO

Groups Beginning 10/1/17

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

Services	HMO B† HSA Qualified	HMO B† HSA Qualified	HMO C
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	Alliance	Alliance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	100%	70%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	60%	100%	70%
Mental Health In-Patient Out-Patient (office visit)	 60% [15] 60% [16]	 100% 100%	 70% 70%
Drug/Substance Abuse In-Patient (Detox Only)	 60% [15]	 100%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 50% See Plan Specific EOC Not Covered 50% [8] Not Covered	 50% See Plan Specific EOC Not Covered 50% [8] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% (ded waived) [12] 100% (in lieu of eyeglasses; ded waived) [12, 13] 100% (ded waived) [12, 13] 1 pair per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 100% 100% 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)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) $25 copay (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)	 UnitedHealthcare Dental CA DHMO Combined Med/Rx/Pediatric dental ded 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

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
3. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or $2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
4. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
5. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
6. For Specialty drugs, please see plan specific EOC.
7. For instances where the contracted rate is less than your copayment, you will only pay the contracted rate.
8. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
9. Maximum member responsibility.

(Foot notes continued on page 79)

Bronze HMO

Groups Beginning 10/1/17

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

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

† HSA Qualified High Deductible Plan

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

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

Bronze HMO

Groups Beginning 10/1/17

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

Services	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Bronze**
Home Health Care (Max 100 visits per year)	60%[1, 4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%[1, 4]
Hospice	100%[1]
Durable Medical Equipment (Covered when medically necessary)	60%[1, 4, 5]
Mental Health In-Patient Out-Patient (office visit)	 60%[1, 4] 60%[1, 4]
Drug/Substance Abuse In-Patient (Detox Only)	 60%[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
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[8]
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% (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. 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. The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.
8. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
9. Maximum member responsibility.
10. Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.

Bronze EPO

Groups Beginning 10/1/17

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

Services	EPO A	EPO B † HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group	Prudent Buyer – Small Group
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [5]	80% (Max 100 visits per benefit period) [5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$1,000 Copay per admit [13]	80% [13]
Hospice	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $1,000 Copay per admit $65 Copay (first 3 visits) [8] – 60%	 80% 80%
Drug/Substance Abuse In-Patient (Detox Only)	 $1,000 Copay per admit	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $65 Copay (first 3 visits) [8] – 60% [7] Not Covered Not Covered Not Covered Not Covered	 80% [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) 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% (ded waived) 50% 50% 50%	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded Combined with Medical 100% 100% (ded waived) 50% 50% 50%

† HSA Qualified High Deductible Plan

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

1. Family Deductible: For any given member, cost share applies either after he/she meets their individual deductible, or after the entire family deductible is met. The family deductible can be met by any combination of amounts from any member, but no one member is required to meet his/her individual deductible.
2. Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.
3. Maximum member responsibility.
4. Classified specialty drugs must obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
5. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.
6. See plan specific EOC for information on preventive services.
7. Evaluation only.
8. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
9. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
10. Medical emergency only.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Additional Footnotes

Gold HMO

(Foot notes continued from page 35)

13. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
14. Maximum member responsibility.
15. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
16. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.
17. In a family plan, an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of Pocket Maximum.
18. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum

Gold PPO

(Foot notes continued from page 45)

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

1. Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.
2. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
10. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Medical emergency only.
15. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold PPO

(Foot notes continued from page 43)

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

1. Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.
2. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
10. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Medical emergency only.
15. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Siver HMO

(Foot notes continued from page 53)

13. In a family plan, an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of Pocket Maximum.
14. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum
15. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
16. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
17. 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.
18. 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.

Silver PPO

(Foot notes continued from page 61)

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

1. Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.
2. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
10. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Medical emergency only.
15. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Bronze HMO

(Foot notes continued from page 69)

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

Bronze HMO

(Foot notes continued from page 71)

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

VALUE PLUS **BENEFITS**

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

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

Dental

Your employer may choose to offer dental coverage as part of your benefits.

California*Choice* members who do not have dental benefits through their employer may get FREE dental savings through Dentegra® Smile Club.

Vision

Members have access to a vision discount program – depending on the coverage your employer selects.

The Voluntary Vision Plan by EyeMed and Voluntary Vision Plan by VSP (both provided by Ameritas) are for an additional cost, while the Vision One EyeCare Discount Program is FREE to all California*Choice* members.

Hearing

Every member has access to hearing benefits through our FREE EPIC Hearing Service Plan (HSP), where you'll get up to 50% savings on brand name hearing aids, reduced costs on services and products, plus a national network of ear physicians and audiologists.

Life

California*Choice* gives employers the option to offer Life Insurance to their employees. If your employer has elected to offer Life Insurance, it will be made available to you at no cost. Simply complete the Beneficiary Section on your Employee Enrollment Application.

Chiropractic

California*Choice* provides an option for employers to offer low-cost chiropractic benefits to employees.

NOTE: Chiropractic benefits will NOT be listed on your Personalized Enrollment Worksheet, but WILL appear on your ValuePlus card if you have access.

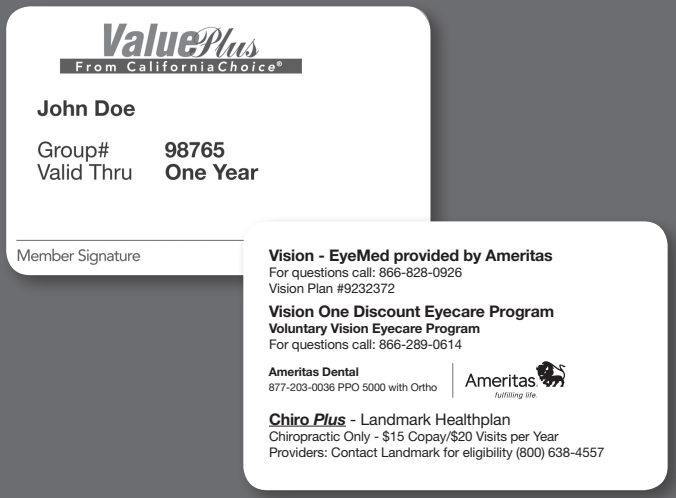
USING YOUR OPTIONAL BENEFITS

Depending on your employer's program selection, you are eligible for the benefits identified on your ValuePlus membership cards, which you will receive once you have submitted your completed enrollment application.

Your ValuePlus benefits, along with instructions on how to access those benefits, will be listed on the back of your ValuePlus membership card.

Your ValuePlus discounts eliminate the need for claim forms because you save on services at the time of purchase. Simply present your membership card to providers when you want to use your benefits.

If you have any questions about your options, go to www.calchoice.com to see your benefits or call our customer service representatives at 800.558.8003.



DENTAL BENEFITS

Through California*Choice*®, members have two options for dental programs. Dentegra® Smile Club is included at no additional cost for all members enrolled in a medical plan. Or, your employer may offer you a prepaid dental benefit or PPO dental plan.

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

Discount Dental

If you enroll in medical coverage through California*Choice*, you're eligible to visit any Dentegra Smile Club dentist from a network of 20,000 providers. Just visit www.calchoice.com, login and click "Dentegra® Smile Club". 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 Dental Programs

California*Choice* 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 prepaid or PPO dental programs.

Prepaid Dental Benefit
Members enrolled in a Prepaid Plan 1000 or 3000 will select a dentist from the extensive SmileSaver Dental provider network.

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

You can refer to your Personalized Enrollment Worksheet, your ValuePlus Optional Benefits card, or visit our website, www.calchoice.com, to view your specific dental benefits.

VISION BENEFITS

All California*Choice*® members are eligible for vision benefits through two great vision programs.

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 California*Choice* medical 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).

FREE Vision One Eyecare Discount Program by EyeMed provided by Ameritas

Save up to 40% on your eyecare needs

Simply visit the participating provider closest to you and present your ValuePlus membership card, which verifies eligibility. Discounted prices are automatically calculated.

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

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.

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 ID card detailing your benefits. When using your benefits, simply go to a participating provider and present your Vision Care ID card 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.

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 California*Choice* Customer Service Center at 800.558.8003 or go to www.calchoice.com.

Hearing loss is the third most chronic ailment in the nation with more than 33 million Americans suffering from some type of hearing loss. And 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 California*Choice*® has selected EPIC HSP 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 California*Choice* 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. 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 INSURANCE **BENEFITS**

Through California*Choice*®, 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.

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.

California*Choice*® 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 ValuePlus card 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 monthy fee and affordable copays with FREE personalized health coaching and education services through its WellCall program.

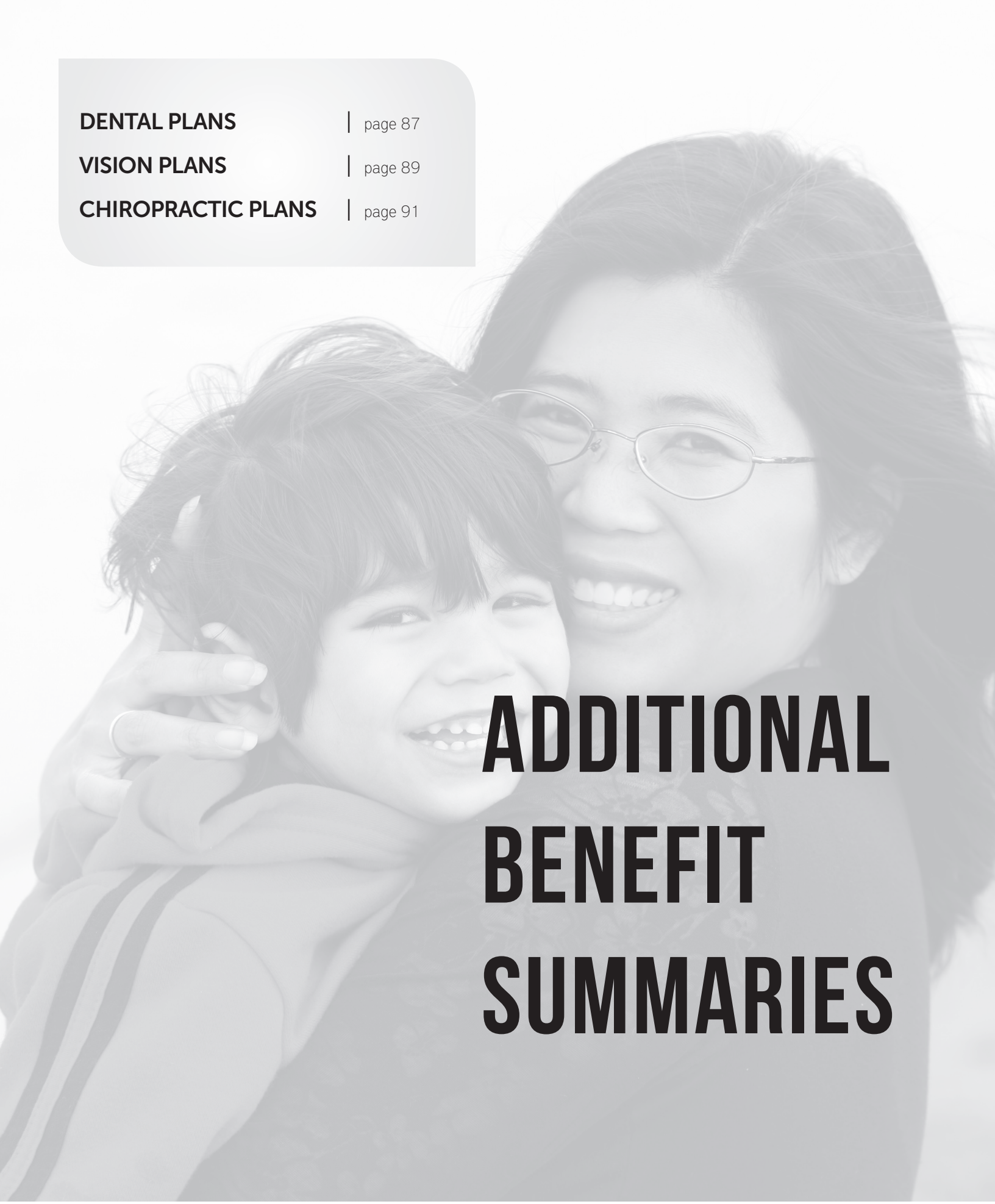
WellCall provides resources or information to meet virtually any need for preventive health and wellness assistance, including weight management, fitness and exercise, smoking cessation, having a healthy pregnancy, parenting, and health- and self-management. Log on* to **www.wellcall.com** or call **888.493.5522** for more information.

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

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 applicances
- WellCall health coaching, education and referral services

For information on specific benefits available through the Chiropractic/ Acupuncture program, see the full Summary of Benefits on page 91.



ADDITIONAL BENEFIT SUMMARIES

There are three great ways to offer employees dental.

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

SmileSaver℠ Dental 3000 and 1000 HMO benefits are available for a low monthly payment and offers office visits, oral exams, X-rays and 2 cleanings per year – FREE! The Dental 3000 HMO can be added as a voluntary plan with no minimum employee participation!

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

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

Note: Copays listed for plans 3000 and 1000 are for services performed by general dentists. Please consult the EOC for specialist copays.
† Cost of high noble metal (gold, etc.) may be charged extra when used. Not to exceed actual laboratory cost of metal.

Continued on page 88

SUMMARY OF DENTAL BENEFITS

Continued from page 87

	Ameritas PPO 3000		Ameritas PPO 3500		Ameritas PPO 4000		Ameritas PPO 5000	
Plan Benefits	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Annual Maximum	$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%	50%	50%	50%	50%	50%	50%
Endo/Perio	50%[1]	50%[1]	80%[1]	50%[1]	80%	50%[1]	80%	50%[1]
"Fusion" Vision Reimbursement Annual Maximum	N/A		$100**		$100**		$100**	

Orthodontia[3]	Ameritas PPO 3000		Ameritas PPO 3500		Ameritas PPO 4000		Ameritas PPO 5000	
Maximum Age 18	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Orthodontia (24 Month Wait)[2]	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	PPO 3500	PPO 4000	PPO 5000
Carry Over Amount	N/A	$250	$250	$250
PPO Bonus	N/A	$100	$100	$150
Benefit Threshold	N/A	$500	$500	$750
Maximum Carry Over Amount	N/A	$1,000	$1,000	$1,000

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

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

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

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

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

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.

*Provided by licensed independent Doctors of Optometry.

1. Coinsurance is member responsibility.

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.

Continued on page 90

Continued from page 89

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

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
WellCall Health Coaching, Education, and Referral Services	**Health Coaching, Education, and Referral Services** WellCall provides resources or information to meet virtually any need for preventive health and wellness assistance, including: weight management, fitness and exercise, smoking cessation, having a healthy pregnancy, parenting, and health self-management. Log on to **www.wellcall.com** or call 888.493.5522.	

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

† Coverage is available for residents in California only.

simple.

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

Anthem Blue Cross	(866) 524-5659	Sharp Health Plan	(800) 359-2002
Health Net	(800) 522-0088	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

calchoice.com

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Your Health. Your Choice.®

A *CHOICE* Administrators® Program

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