BENEFIT SUMMARIES

CaliforniaChoice®
Your Health. Your Choice.®

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4.1.2025

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Knowledge Management & Learning Specialist
*and **CaliforniaChoice**® Member*

A WIFE & MOTHER
A CREATOR
PASSIONATE

I AM CALIFORNIA DIFFERENT®

Anthem
health net
KAISER PERMANENTE®
SHARP Health Plan
Sutter Health Plan
United Healthcare
westernhealth ADVANTAGE

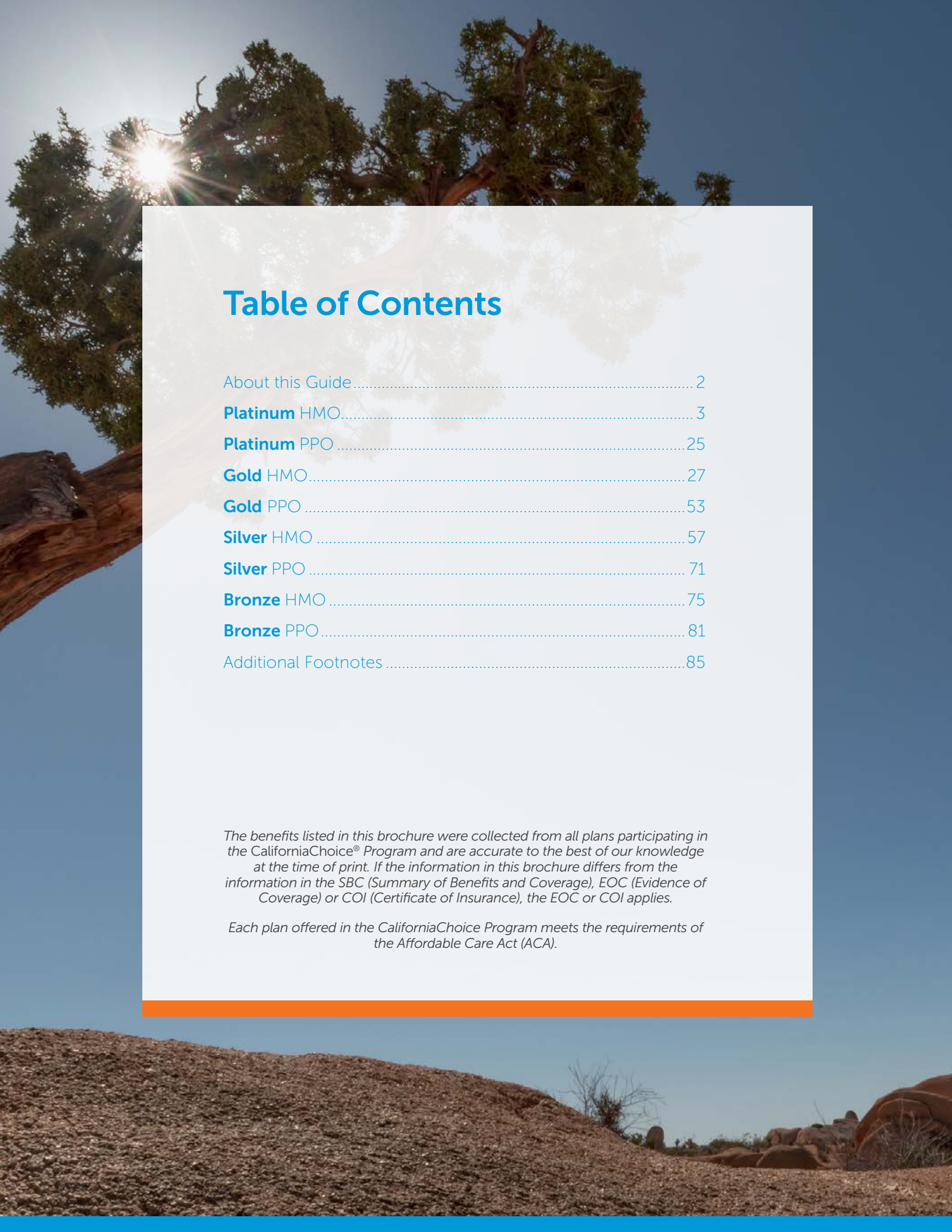


Table of Contents

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

Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

About This Guide

Trusted by Californians for over 25 years.

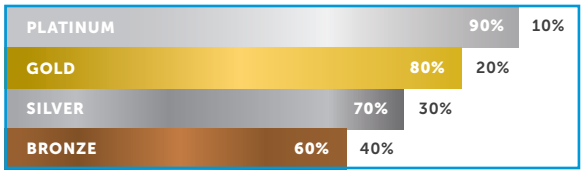
When we started CaliforniaChoice® in 1996, the idea of offering a program that provided small businesses and their employees access to multiple health insurance carriers and benefits was truly revolutionary. Today, we're pleased to offer seven health plans and 110 HMO, PPO and HSA plan design options.

Greater access to doctors, specialists, and hospitals

CaliforniaChoice offers health plans in all of the Affordable Care Act's (ACA) four metal tiers: Bronze, Silver, Gold, and Platinum. Each tier offers a different percentage of shared health care costs for the employee, ranging from 10% to 40% (with the health plan paying the other 90% to 60%), as shown to the right. This can significantly increase the number of plans, doctors, and specialists available to your employees.

Here is how insurance metal tiers work

METAL TIERS: (% Paid by Health Plan / Employee)



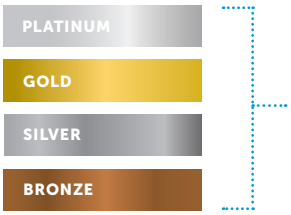
Please keep in mind that some plans may pay a different percentage of health care costs than what is shown above for each tier; refer to each plan's summary of benefits for specific covered percentage details.

1. Choose Your Metal Tier(s)

Choose **Total Choice** (four tiers), or choose **Triple, Double**, or **Single Choice**

TOTAL CHOICE

Offers employees access to health plans and benefits available in all four tiers.



TRIPLE CHOICE

Offers employees access to the health plans and benefits available in three neighboring tiers.

DOUBLE CHOICE

Offers employees access to the health plans and benefits available in two neighboring tiers.

SINGLE CHOICE

Offers employees access to the health plans and benefits available in a single tier.

2. Define Your Monthly Contribution

Your broker will share plan premium information with you. Select your preferred plan and whether you want to pay a **Fixed Percentage** of costs (select from 50% to 100%) or a **Fixed Dollar Amount** toward that plan.

3. Employees Select Their Benefits

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

On the following pages you'll find a summary of the benefits offered in each tier level.
*For more information, please contact your broker or visit **calchoice.com.***

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	Vivity	WholeCare
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [9]	$3,350 / $6,700 [9]	$2,700 / $5,400
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$30 Copay
Specialist Visit (SPC)	$40 Copay	$40 Copay	$50 Copay
Laboratory	$10 Copay [18]	$25 Copay [18]	$30 Copay
X-Ray	$10 Copay [18]	$25 Copay [18]	$30 Copay
MRI, CT and PET (office setting)	$100 Copay [20]	$100 Copay [20]	$250 Copay per procedure
Virtual/Telemedicine Office Visit	$20 Copay / $40 Copay [21]	100% / $40 Copay [21]	100%
Hospital Services – In-Patient	$300 Copay per day – 3 days max per admit	$250 Copay per day – 4 days max per admit	$600 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$150 Copay	$250 Copay
Urgent Care	$20 Copay	$20 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay $200 Copay	 $150 Copay $150 Copay	 $500 Copay $200 Copay [2]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$40 Copay	$50 Copay
Ambulance Services (per trip)	$150 Copay [15]	$150 Copay [15]	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $5 Copay / Level 2 $15 Copay [16] Level 1 $20 Copay / Level 2 $30 Copay [16] Level 1 $50 Copay / Level 2 $60 Copay [16] Level 1 70% / Level 2 60% (up to $250 per prescription [14]) (prior auth. required) [12, 16]	 Level 1 $5 Copay / Level 2 $15 Copay [16] Level 1 $25 Copay / Level 2 $35 Copay [16] Level 1 $75 Copay / Level 2 $85 Copay [16] Level 1 $250 Copay / Level 2 $250 Copay (prior auth. required) [12, 16]	 $5 Copay [6, 7] $30 Copay [6, 7] $50 Copay [6, 7] 70% (up to $250 per prescription [14]) (prior auth. required) [6, 7]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [16]	Applicable Rx Copay [16]	Applicable Rx Copay [6,7]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered [22]	Covered [22]	$50 Copay
Chemotherapy	$125 Copay	$250 Copay	$30 Copay
Chiropractic (20 visits max per year)	$15 Copay (30 visits max per benefit period) [17]	$15 Copay (30 visits max per benefit period) [17]	Not Covered
Acupuncture	$20 Copay	$20 Copay	$15 Copay [1]
Physical, Occupational, Speech Therapy	$20 Copay [18]	$30 Copay [18]	$30 Copay [18]
Rehabilitative & Habilitative Services and Devices	$20 Copay [18]	$30 Copay [18]	$30 Copay [18]
Home Health Care (Max 100 visits per year)	$40 Copay (Max 100 visits per benefit period) [11]	$40 Copay (Max 100 visits per benefit period) [11]	$30 Copay

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	Vivity	WholeCare
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$100 Copay per day – 3 days max per admit [19]	$150 Copay per day – 4 days max per admit [19]	$25 Copay per day (no limit)
Hospice (out-patient)	100%	$40 Copay	100%
Durable Medical Equipment (Covered when medically necessary)	50%	$100 Copay	70%
Mental Health			
In-Patient	$300 Copay per day – 3 days max per admit	$250 Copay per day – 4 days max per admit	$600 Copay per day – 4 days max [5]
Out-Patient (office visit)	$20 Copay	$20 Copay	$30 Copay [5]
Drug/Substance Abuse			
In-Patient (Detox Only)	$300 Copay per day – 3 days max per admit	$250 Copay per day – 4 days max per admit	$600 Copay per day – 4 days max
Infertility			
Infertility Evaluation and Treatment	$20 Copay [13]	$20 Copay [13]	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	Anthem Vision	EyeMed [10]
Network	Blue View Vision	Blue View Vision	EyeMed
Exam	100%	100%	100%
Contact Lenses	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	100%
Frames	100%	100%	1 pair per calendar year
Maximum Allowance per year	1 per calendar year	1 per calendar year	None
Pediatric Dental			
Carrier	Anthem Dental	Anthem Dental	Dental Benefit Providers [8, 10]
Network	Prime	Prime	Dental Benefit Providers
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	80%	80%	Copay varies by service
Major Services (no waiting period)	50%	50%	Copay varies by service
Orthodontics (medically necessary)	50%	50%	Copay varies by service

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. Must be medically necessary.
2. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
3. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
4. See plan specific EOC for information on preventive services.
5. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
6. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
10. Pediatric dental and vision are included on all plans.
11. Limited to 100 4-hour visits per benefit period.
12. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
13. Evaluation only.
14. Maximum member responsibility.
15. Medical emergency only.
16. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
17. Manipulation Therapy only: benefit maximum of 30 visits per benefit period for office visits.
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.
21. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
22. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO E	HMO F	HMO G
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Full	WholeCare	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,700 / $5,400	$3,850 / $7,700	$3,850 / $7,700 [11]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	100%	100%
Specialist Visit (SPC)	$50 Copay	100%	100%
Laboratory	$30 Copay	100%	100%
X-Ray	$30 Copay	100%	100%
MRI, CT and PET (office setting)	$250 Copay per procedure	$275 Copay per procedure	$275 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$600 Copay per day – 4 days max	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$275 Copay	$275 Copay
Urgent Care	$30 Copay	100%	100%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $200 Copay [1]	 $500 Copay $200 Copay [1]	 $500 Copay $200 Copay [1]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	100%	100%
Ambulance Services (per trip)	$250 Copay	$275 Copay	$275 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay [2, 4] $30 Copay [2, 4] $50 Copay [2, 4] 70% (up to $250 per prescription [5]) (prior auth. required) [2, 4]	 100% [2, 4] $30 Copay [2, 4] $50 Copay [2, 4] 70% (up to $250 per prescription [5]) (prior auth. required) [2, 4]	 100% [2, 4] $30 Copay [2, 4] $50 Copay [2, 4] 70% (up to $250 per prescription [5]) (prior auth. required) [2, 4]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [2, 4]	Applicable Rx Copay [2, 4]	Applicable Rx Copay [2, 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% [6]	100% [6]	100% [6]
Chronic Disease Management	$50 Copay	100%	100%
Chemotherapy	$30 Copay	100%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$15 Copay [3]	$15 Copay [3]	$15 Copay [3]
Physical, Occupational, Speech Therapy	$30 Copay [7]	100% [7]	100% [7]
Rehabilitative & Habilitative Services and Devices	$30 Copay [7]	100% [7]	100% [7]
Home Health Care (Max 100 visits per year)	$30 Copay	100%	100%

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO E	HMO F	HMO G
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Full	WholeCare	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	70%	70%
Mental Health			
In-Patient	$600 Copay per day – 4 days max [8]	$500 Copay per day – 4 days max [8]	$500 Copay per day – 4 days max [8]
Out-Patient (office visit)	$30 Copay [8]	100% [8]	100% [8]
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day – 4 days max	$500 Copay per day – 4 days max	$500 Copay per day – 4 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	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 [9, 10]	Dental Benefit Providers [9, 10]	Dental Benefit Providers [9, 10]
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

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
2. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
3. Must be medically necessary.
4. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
5. Maximum member responsibility.
6. See plan specific EOC for information on preventive services.
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
9. Pediatric dental and vision are included on all plans.
10. 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.
11. 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.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO H	HMO I	HMO J
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Full	SmartCare	SmartCare
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,850 / $7,700	$3,850 / $7,700	$2,700 / $5,400
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	100%	$30 Copay
Specialist Visit (SPC)	100%	100%	$50 Copay
Laboratory	100%	100%	$30 Copay
X-Ray	100%	100%	$30 Copay
MRI, CT and PET (office setting)	$275 Copay per procedure	$275 Copay per procedure	$250 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$500 Copay per day – 4 days max	$500 Copay per day - 4 days max	$600 Copay per day - 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$275 Copay	$250 Copay
Urgent Care	100%	100%	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $200 Copay [8]	 $500 Copay $200 Copay [8]	 $500 Copay $200 Copay [8]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	100%	100%	$50 Copay
Ambulance Services (per trip)	$275 Copay	$275 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% [6, 10] $30 Copay [6, 10] $50 Copay [6, 10] 70% (up to $250 per prescription [9]) (prior auth. required) [6, 10]	 100% [6, 10] $30 Copay [6, 10] $50 Copay [6, 10] 70% (up to $250 per prescription [9]) (prior auth. required) [6, 10]	 $5 Copay [6, 10] $30 Copay [6, 10] $50 Copay [6, 10] 70% (up to $250 per prescription [9]) (prior auth. required) [6, 10]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [6, 10]	Applicable Rx Copay [6, 10]	Applicable Rx Copay [6, 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% [5]	100% [5]	100% [5]
Chronic Disease Management	100%	100%	$50 Copay
Chemotherapy	100%	100%	$30 Copay
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$15 Copay [2]	$15 Copay [2]	$15 Copay [2]
Physical, Occupational, Speech Therapy	100% [3]	100% [3]	$30 Copay [3]
Rehabilitative & Habilitative Services and Devices	100% [3]	100% [3]	$30 Copay [3]
Home Health Care (Max 100 visits per year)	100%	100%	$30 Copay

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO H	HMO I	HMO J
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Full	SmartCare	SmartCare
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	70%	70%
Mental Health			
In-Patient	$500 Copay per day – 4 days max[1]	$500 Copay per day – 4 days max[1]	$500 Copay per day – 4 days max[1]
Out-Patient (office visit)	100%[1]	100%[1]	$30 Copay[1]
Drug/Substance Abuse			
In-Patient (Detox Only)	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max	$600 Copay per day – 4 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	EyeMed[7]	EyeMed[7]	EyeMed[7]
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[4, 7]	Dental Benefit Providers[4, 7]	Dental Benefit Providers[4, 7]
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

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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2. Must be medically necessary.
3. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
4. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
5. See plan specific EOC for information on preventive services.
6. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
7. Pediatric dental and vision are included on all plans.
8. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
9. Maximum member responsibility.
10. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
11. 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.

Platinum HMO

Groups Beginning 4.1.2025

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

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Home Health Care (Max 100 visits per year)	100% [5]	$20 Copay [5]	100% (ded waived) [5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$250 Copay per admit	$150 Copay per day – 5 days max	$250 Copay per admit
Hospice (out-patient)	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	90% [6, 11]	90% [6, 11]	90% [6, 11]
Mental Health			
In-Patient	$500 Copay per admit	$250 Copay per day – 5 days max	$500 Copay per admit
Out-Patient (office visit)	$10 Copay	$20 Copay	$30 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	$500 Copay per admit	$250 Copay per day – 5 days max	$500 Copay per admit
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	Kaiser Permanente
Network	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Exam	100%	100%	100% (ded waived)
Contact Lenses	1 pair per calendar year [9]	1 pair per calendar year [9]	1 pair per calendar year [9]
Frames	1 pair per calendar year [9]	1 pair per calendar year [9]	1 pair per calendar year (ded waived) [9]
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700	$350 / $700
Office Visit	100%	100%	100% (ded waived)
Diagnostic & Preventative (D&P)	100%	100%	100% (ded waived)
Basic Services	$40 Copay [7]	$40 Copay [7]	$40 Copay [7]
Major Services (no waiting period)	$365 Copay [8]	$365 Copay [8]	$365 Copay [8]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. 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.
2. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximun per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
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. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
8. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
9. 1 pair of glasses or 1 pair of contact lenses per accumulation period.5. 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).
10. 20 visits max per year combined for Chiropractic and Acupuncture.
11. Supplemental Durable Medical Equipment has a $2,000 annual maximum.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sharp Health Plan
Network Name	Premier	Performance	Premier
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [3]	$3,800 / $7,600 [3]	$4,000 / $8,000 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$15 Copay	$15 Copay	$10 Copay
Specialist Visit (SPC)	$20 Copay	$30 Copay	$20 Copay
Laboratory	100%	100%	$10 Copay
X-Ray	100%	100%	$40 Copay
MRI, CT and PET (office setting)	$150 Copay	$100 Copay	$150 Copay
Virtual/Telemedicine Office Visit	Covered as any Illness	Covered as any Illness	Covered as any Illness
Hospital Services – In-Patient	$400 Copay	85%	$350 Copay per day – 5 days max
In-Patient Physician Fees	100%	85%	100%
Emergency Room (copay waived if admitted)	$150 Copay	85%	$200 Copay
Urgent Care	$20 Copay	$30 Copay	$20 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 85% 85%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$20 Copay	$30 Copay	$20 Copay
Ambulance Services (per trip)	$150 Copay	85%	$200 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100% (if in formulary)
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	$400 Copay [7]	85% [7]	$350 Copay per day – 5 days max [7]
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	$20 Copay	$30 Copay	$20 Copay
Chemotherapy	Variable [6]	Variable [6]	Variable [6]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$15 Copay	$15 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$15 Copay	$15 Copay	$10 Copay
Rehabilitative & Habilitative Services and Devices	$15 Copay	$15 Copay	$10 Copay

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sharp Health Plan
Network Name	Premier	Performance	Premier
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Home Health Care (Max 100 visits per year)	$15 Copay	$15 Copay	$10 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay	85%	$200 Copay
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $400 Copay $15 Copay	 85% $15 Copay	 $150 Copay per day – 5 days max $10 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $400 Copay	 85%	 $150 Copay per day – 5 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP Advantage Network 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 of California Delta Dental DeltaCare USA None Combined with Medical 100% [5] 100% [8] $25 Copay [1] $300 Copay [2] $1,000 Copay [9]	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [5] 100% [8] $25 Copay [1] $300 Copay [2] $1,000 Copay [9]	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [5] 100% [8] $25 Copay [1] $300 Copay [2] $1,000 Copay [9]

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. Refers to procedure code D2140
2. Refers to procedure code D3330
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. Refers to procedure code D0999
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Amount listed for In-Patient Services only.
8. Refers to procedure codes D0120 and D1120/D1110
9. Refers to procedure code D8080/D8090

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO A
Participating Health Plans	Sutter Health Plan	Sutter Health Plan	UnitedHealthcare
Network Name	Sutter Health Plan	Sutter Health Plan	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,500 / $9,000 [11]	$3,500 / $7,000 [11]	$4,000 / $8,000 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay [14]	$15 Copay [14]	$25 Copay
Specialist Visit (SPC)	$30 Copay	$30 Copay	$50 Copay
Laboratory	$20 Copay	$15 Copay	$25 Copay
X-Ray	$30 Copay per procedure	$25 Copay per procedure	$25 Copay
MRI, CT and PET (office setting)	$100 Copay per procedure	$150 Copay per procedure	$200 Copay per procedure
Virtual/Telemedicine Office Visit	Variable [13]	Variable [13]	100%
Hospital Services – In-Patient	$250 Copay per day – 5 days max per admit	$250 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	100%	100%	80%
Emergency Room (copay waived if admitted)	$150 Copay	$100 Copay	80%
Urgent Care	$20 Copay	$15 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 $100 Copay $100 Copay	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$30 Copay	$30 Copay	$50 Copay
Ambulance Services (per trip)	$150 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay [12] $20 Copay [12] $30 Copay [12] 90% (up to $250 per prescription [5]) [12]	 $5 Copay [12] $15 Copay [12] $30 Copay [12] 90% (up to $250 per prescription [5]) [12]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [4] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [4] Tier 3 Non-specialty $80 Copay / Tier 3 Specialty $250 Copay [4] Tier 4 75% (up to $250 per prescription [5]) [2]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [12]	Applicable Rx Copay [12]	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% [1]	100% [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	90%	90%	$150 Copay [7]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	$15 Copay
Acupuncture	$20 Copay	$15 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$15 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$15 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$15 Copay	$25 Copay

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO A
Participating Health Plans	Sutter Health Plan	Sutter Health Plan	UnitedHealthcare
Network Name	Sutter Health Plan	Sutter Health Plan	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 5 days max per admit	$150 Copay per day – 5 days max per admit	80%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	90%	90%	$70 Copay
Mental Health			
In-Patient	$250 Copay per day – 5 days max per admit [9]	$250 Copay per day – 5 days max per admit [9]	80%
Out-Patient (office visit)	$20 Copay	$15 Copay	$30 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$250 Copay per day – 5 days max per admit [9]	$250 Copay per day – 5 days max per admit [9]	80%
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	UnitedHealthcare Vision
Network	Choice Network	Choice Network	UnitedHealthcare Vision
Exam	100% [8]	100% [8]	100%
Contact Lenses	100% (in lieu of eyeglasses) [8, 10]	100% (in lieu of eyeglasses) [8, 10]	80%
Frames	100% (in lieu of contact lenses) [8, 10]	100% (in lieu of contact lenses) [8, 10]	80%
Maximum Allowance per year	1 pair per year	1 pair per year	1 per calendar year
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	UnitedHealthcare Dental
Network	DeltaCare USA	DeltaCare USA	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	Copay varies by service	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. See plan specific EOC for information on preventive services.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
4. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/ member-resources/pharmacy-benefits/prescription-drug-lists.
5. Maximum member responsibility.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
8. 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.
9. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for autism spectrum disorder.
10. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every calendar year
11. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
12. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be up to four times the retail cost share. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
13. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.
14. Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk-in Care visits.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C	HMO E
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [1]	$4,000 / $8,000 [1]	$3,000 / $6,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$25 Copay	$25 Copay
Specialist Visit (SPC)	$40 Copay	$50 Copay	$50 Copay
Laboratory	$20 Copay	$25 Copay	$25 Copay
X-Ray	$20 Copay	$25 Copay	$25 Copay
MRI, CT and PET (office setting)	$150 Copay per procedure	$200 Copay per procedure	$150 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$300 Copay per day – 3 days max per admit	80%	$400 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	80%	100%
Emergency Room (copay waived if admitted)	$250 Copay	80%	$400 Copay
Urgent Care	$75 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay $200 Copay	 80% 80%	 $250 Copay $250 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $50 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $80 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx 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% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [5]	$150 Copay [5]	$150 Copay [5]
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	$25 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$25 Copay	$25 Copay

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C	HMO E
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Home Health Care (Max 100 visits per year)	$20 Copay	$25 Copay	$25 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 3 days max per admit	80%	$300 Copay per day – 5 days max per admit
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	$70 Copay
Mental Health In-Patient Out-Patient (office visit)	 $300 Copay per day – 3 days max per admit $30 Copay	 80% $30 Copay	 $400 Copay per day – 5 days max per admit $30 Copay
Drug/Substance Abuse In-Patient (Detox Only)	$300 Copay per day – 3 days max per admit	80%	$400 Copay per day – 5 days max per admit
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% 90% 90% 1 per calendar year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% 80% 80% 1 per calendar year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% 90% 90% 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 $350 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $350 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO G	HMO H	HMO I
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	Harmony
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000 [1]	$4,000 / $8,000 [1]	$3,000 / $6,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$25 Copay	$25 Copay
Specialist Visit (SPC)	$50 Copay	$50 Copay	$50 Copay
Laboratory	$25 Copay	$25 Copay	$25 Copay
X-Ray	$25 Copay	$25 Copay	$25 Copay
MRI, CT and PET (office setting)	$150 Copay per procedure	$200 Copay per procedure	$150 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$400 Copay per day – 5 days max per admit	80%	$400 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	80%	100%
Emergency Room (copay waived if admitted)	$400 Copay	80%	$400 Copay
Urgent Care	$75 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay $250 Copay	 80% 80%	 $250 Copay $250 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $80 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx 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% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [5]	$150 Copay [5]	$150 Copay [5]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$25 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$25 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$25 Copay	$25 Copay	$25 Copay

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO G	HMO H	HMO I
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	Harmony
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max per admit	80%	$300 Copay per day - 5 days max per admit
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	$70 Copay
Mental Health			
In-Patient	$400 Copay per day – 5 days max per admit	80%	$400 Copay per day - 5 days max per admit
Out-Patient (office visit)	$30 Copay	$30 Copay	$30 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$400 Copay per day – 5 days max per admit	80%	$400 Copay per day - 5 days max per admit
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	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100%	100%	100%
Contact Lenses	90%	80%	90%
Frames	90%	80%	90%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	CA DHMO	CA DHMO	CA DHMO
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)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO J	HMO K	HMO L
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,500 / $7,000 [1]	$3,500 / $7,000 [1]	$3,500 / $7,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$25 Copay	$25 Copay
Specialist Visit (SPC)	$50 Copay	$50 Copay	$50 Copay
Laboratory	$25 Copay	$25 Copay	$25 Copay
X-Ray	$25 Copay	$25 Copay	$25 Copay
MRI, CT and PET (office setting)	$200 Copay per procedure	$200 Copay per procedure	$200 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	90%	90%	90%
In-Patient Physician Fees	90%	90%	90%
Emergency Room (copay waived if admitted)	$400 Copay	$400 Copay	$400 Copay
Urgent Care	$75 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 90% 90%	 90% 90%	 90% 90%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay /Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx 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% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [5]	$150 Copay [5]	$150 Copay [5]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$25 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$25 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$25 Copay	$25 Copay	$25 Copay

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO J	HMO K	HMO L
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	90%	90%	90%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	$70 Copay
Mental Health			
In-Patient	90%	90%	90%
Out-Patient (office visit)	$30 Copay	$30 Copay	$30 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	90%	90%	90%
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	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100%	100%	100%
Contact Lenses	90%	90%	90%
Frames	90%	90%	90%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	CA DHMO	CA DHMO	CA DHMO
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)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO M	HMO N	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Harmony	Alliance	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [1]	$2,500 / $5,000 [1]	$4,000 / $8,000 [7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$25 Copay
Specialist Visit (SPC)	$40 Copay	$40 Copay	$25 Copay
Laboratory	$20 Copay	$20 Copay	100%
X-Ray	$20 Copay	$20 Copay	100%
MRI, CT and PET (office setting)	$150 Copay per procedure	$150 Copay per procedure	$100 Copay
Virtual/Telemedicine Office Visit	100%	100%	Variable [14]
Hospital Services – In-Patient	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max	$250 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay	$150 Copay
Urgent Care	$75 Copay	$75 Copay	$50 Copay
Hospital Services – Out-Patient			
Surgical Facility	$200 Copay	$200 Copay	$100 Copay
Ambulatory Surgery Center	$200 Copay	$200 Copay	$100 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$40 Copay	$25 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	100%
Rx Benefits			
Generic	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6]	$10 Copay
Formulary Brand	Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [6]	Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [6]	$30 Copay [13]
Non-Formulary Brand	Tier 3 Non-specialty $50 Copay / Tier 3 Specialty $250 Copay [6]	Tier 3 Non-specialty $50 Copay / Tier 3 Specialty $250 Copay [6]	$50 Copay [13]
Specialty	Tier 4 75% (up to $250 per prescription [3]) [2]	Tier 4 75% (up to $250 per prescription [3]) [2]	80% (up to $250 per 30 day supply [3]) [9]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay	$30 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% [4]	100% [4]	100% [4, 8]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [5]	$150 Copay [5]	100%
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay [13]
Acupuncture	$10 Copay	$10 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$20 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$20 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$20 Copay	100%

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO M	HMO N	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Harmony	Alliance	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max per admit	$250 Copay per day – Days 1-5
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	80% [9, 10]
Mental Health			
In-Patient	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max per admit	$250 Copay per day – Days 1-5
Out-Patient (office visit)	$30 Copay	$30 Copay	$25 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max per admit	$250 Copay per day – Days 1-5
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	UnitedHealthcare Vision	UnitedHealthcare Vision	EyeMed
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	Eyewear Only
Exam	100%	100%	100%
Contact Lenses	90%	90%	100%
Frames	90%	90%	100%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year [11]
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	Delta Dental
Network	CA DHMO	CA DHMO	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$1,000 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/ member-resources/pharmacy-benefits/prescription-drug-lists.
7. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
8. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
9. Percentage copayment amounts are based on WHA's contracted rates with the provider of service or medication.
10. See copayment summary for applicable prosthetic/orthotic device copayment amount.
11. Limited to one pair of glasses with standard lenses and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable contact lenses instead of glasses.
12. Copayments do not contribute to out-of-pocket maximum.
13. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or contribute to the out-of-pocket maximum.
14. Cost share amount varies based on type of services rendered.

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C
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	$4,500 / $9,000 [1]	$5,500 / $11,000 [1]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$20 Copay
Specialist Visit (SPC)	$30 Copay	$20 Copay
Laboratory	$20 Copay	100%
X-Ray	$30 Copay	100%
MRI, CT and PET (office setting)	$100 Copay	$150 Copay
Virtual/Telemedicine Office Visit	Variable [10]	Variable [10]
Hospital Services – In-Patient	$250 Copay per day – Days 1-5	100%
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	$150 Copay	$150 Copay
Urgent Care	$20 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 $150 Copay $150 Copay
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$30 Copay	$20 Copay
Ambulance Services (per trip)	$150 Copay	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay $20 Copay [9] $30 Copay [9] 90% (up to $250 per 30 day supply [6]) [3]	 $5 Copay $30 Copay [9] $50 Copay [9] 80% (up to $250 per 30 day supply [6]) [3]
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	$20 Copay	$30 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	90% [3]	100%
Chiropractic (20 visits max per year)	$15 Copay [8]	$15 Copay [8]
Acupuncture	$15 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	100%

Platinum HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C
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)	$150 Copay per day – Days 1-5	100%
Hospice (out-patient)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	90% [3, 4]	80% [3, 4]
Mental Health		
In-Patient	$250 Copay per day – Days 1-5	100%
Out-Patient (office visit)	$20 Copay	$20 Copay
Drug/Substance Abuse		
In-Patient (Detox Only)	$250 Copay per day – Days 1-5	100%
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	EyeMed	EyeMed
Network	Eyewear Only	Eyewear Only
Exam	100%	100%
Contact Lenses	100%	100%
Frames	100%	100%
Maximum Allowance per year	1 per calendar year [7]	1 per calendar year [7]
Pediatric Dental		
Carrier	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA
Deductible	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Office Visit	100%	100%
Diagnostic & Preventative (D&P)	100%	100%
Basic Services	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* 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 or medication.
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 and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable contact lenses instead of glasses.
8. Copayments do not contribute to out-of-pocket maximum.
9. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or contribute to the out-of-pocket maximum.
10. Cost share amount varies based on type of services rendered.

Platinum PPO

Groups Beginning 4.1.2025

Services	PPO A	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Platinum**	
	In-Network	Out-of-Network [9]
Calendar Year Deductible*	None	$2,000 / $4,000 [17] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000 [1]	$16,000 / $32,000 [1]
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	$10 Copay	50%
Specialist Visit (SPC)	$35 Copay	50%
Laboratory	$10 Copay	50%
X-Ray	$10 Copay	50%
MRI, CT and PET (office setting)	90% [14]	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	$10 Copay / $35 Copay [15]	50%
Hospital Services – In-Patient	90%	50% (up to $650 per day) [5]
In-Patient Physician Fees	90%	50%
Emergency Room (copay waived if admitted)	$500 Copay – 90%	
Urgent Care	$10 Copay	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay per admit – 90% $50 Copay per admit – 90%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required	
2nd Surgical Opinion	$35 Copay	50%
Ambulance Services (per trip)	90% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $5 Copay / Level 2 $15 Copay [2] Level 1 $15 Copay / Level 2 $25 Copay [2] Level 1 $45 Copay / Level 2 $55 Copay [2] Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered
Diabetes – Self-Injectable	Applicable Rx Copay	Not Covered
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any Illness	
Preventive/Wellness Services	100% [3]	50% [3]
Chronic Disease Management	Covered [16]	
Chemotherapy	90%	50% [14]
Chiropractic (20 visits max per year)	$15 Copay (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$10 Copay	Not Covered

Platinum PPO

Groups Beginning 4.1.2025

Services	PPO A	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Platinum**	
	In-Network	Out-of-Network [9]
Physical, Occupational, Speech Therapy	$10 Copay	50% [14]
Rehabilitative & Habilitative Services and Devices	$10 Copay [11]	50% [11]
Home Health Care (Max 100 visits per year)	90% (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)	90% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	
Mental Health		
In-Patient	90%	50% (up to $650 per day) [5]
Out-Patient (office visit)	$10 Copay	50%
Drug/Substance Abuse		
In-Patient (Detox Only)	90%	50% (up to $650 per day) [5]
Infertility		
Infertility Evaluation and Treatment	$10 Copay [7]	50% [7]
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	Anthem Vision	Anthem Vision
Network	Blue View Vision	
Exam	100%	$0 Copayment plus any charges in excess of maximum allowed amount (ded waived)
Contact Lenses	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of maximum allowed amount (ded waived)
Frames	100% (1 per calendar year)	$0 Copayment plus any charges in excess of maximum allowed amount (ded waived)
Maximum Allowance per year	1 per calendar year	1 per calendar year
Pediatric Dental		
Carrier	Anthem Dental	Anthem Dental
Network	Prime	
Deductible	None	None
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%
Diagnostic &Preventative (D&P)	100%	100%
Basic Services	80%	80%
Major Services (no waiting period)	50%	50%
Orthodontics (medically necessary)	50%	50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.
17. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Network Name	Select HMO	CaliforniaCare HMO	Priority Select HMO
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible *	None	None	None
Out-of-Pocket Max Ind/Fam	$7,250 / $14,500 [4]	$7,250 / $14,500 [4]	$7,250 / $14,500 [4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$30 Copay	$30 Copay
Specialist Visit (SPC)	$60 Copay	$60 Copay	$60 Copay
Laboratory	$15 Copay [7]	$15 Copay [7]	$15 Copay [7]
X-Ray	$15 Copay [7]	$15 Copay [7]	$15 Copay [7]
MRI, CT and PET (office setting)	$100 Copay [12]	$100 Copay [12]	$100 Copay [12]
Virtual/Telemedicine Office Visit	$30 Copay / $60 Copay [13]	$30 Copay / $60 Copay [13]	$30 Copay / $60 Copay [13]
Hospital Services – In-Patient	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$325 Copay	$325 Copay	$325 Copay
Urgent Care	$30 Copay	$30 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $450 Copay	 $500 Copay $450 Copay	 $500 Copay $450 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay	$60 Copay	$60 Copay
Ambulance Services (per trip)	$150 Copay [1]	$150 Copay [1]	$150 Copay [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $10 Copay / Level 2 $20 Copay [2] Level 1 $50 Copay / Level 2 $60 Copay [2] Level 1 $90 Copay / Level 2 $100 Copay [2] Level 1 70% / Level 2 60% (up to $250 per prescription [10]) (prior auth. required) [2, 8]	 Level 1 $10 Copay / Level 2 $20 Copay [2] Level 1 $50 Copay / Level 2 $60 Copay [2] Level 1 $90 Copay / Level 2 $100 Copay [2] Level 1 70% / Level 2 60% (up to $250 per prescription [10]) (prior auth. required) [2, 8]	 Level 1 $10 Copay / Level 2 $20 Copay [2] Level 1 $50 Copay / Level 2 $60 Copay [2] Level 1 $90 Copay / Level 2 $100 Copay [2] Level 1 70% / Level 2 60% (up to $250 per prescription [10]) (prior auth. required) [2, 8]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [2]	Applicable Rx Copay [2]	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% [3]	100% [3]	100% [3]
Chronic Disease Management	Covered [14]	Covered [14]	Covered [14]
Chemotherapy	$125 Copay	$125 Copay	$125 Copay
Chiropractic (20 visits max per year)	$15 Copay (30 visits max per benefit period) [6]	$15 Copay (30 visits max per benefit period) [6]	$15 Copay (30 visits max per benefit period) [6]
Acupuncture	$30 Copay	$30 Copay	$30 Copay
Physical, Occupational, Speech Therapy	$30 Copay [7]	$30 Copay [7]	$30 Copay [7]
Rehabilitative & Habilitative Services and Devices	$30 Copay [7]	$30 Copay [7]	$30 Copay [7]

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Network Name	Select HMO	CaliforniaCare HMO	Priority Select HMO
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	$60 Copay (Max 100 visits per benefit period)[5]	$60 Copay (Max 100 visits per benefit period)[5]	$60 Copay (Max 100 visits per benefit period)[5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 4 days max per admit [11]	$300 Copay per day – 4 days max per admit [11]	$300 Copay per day – 4 days max per admit [11]
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health			
In-Patient	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit
Out-Patient (office visit)	$30 Copay	$30 Copay	$30 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit
Infertility			
Infertility Evaluation and Treatment	$30 Copay [9]	$30 Copay [9]	$30 Copay [9]
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision	Blue View Vision	Blue View Vision
Exam	100%	100%	100%
Contact Lenses	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)
Frames	100%	100%	100%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime	Prime	Prime
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	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. Medical emergency only.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
5. Limited to 100 4-hour visits per benefit period.
6. Manipulation Therapy only: benefit maximum of 30 visits per benefit period for office visits.
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
9. Evaluation only.
10. Maximum member responsibility.
11. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
12. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
13. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
14. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$7,250 / $14,500	$7,500 / $15,000	$7,350 / $14,700
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$40 Copay	$35 Copay
Specialist Visit (SPC)	$50 Copay	$60 Copay	$55 Copay
Laboratory	$40 Copay	$40 Copay	$40 Copay
X-Ray	$40 Copay	$50 Copay	$50 Copay
MRI, CT and PET (office setting)	$325 Copay per procedure	$350 Copay per procedure	$325 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$750 Copay per day – 4 days max	$750 Copay per day – 5 days max	$750 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$325 Copay	$350 Copay	$325 Copay
Urgent Care	$30 Copay	$40 Copay	$35 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $900 Copay $360 Copay [2]	 $1,200 Copay $480 Copay [2]	 $1,200 Copay $480 Copay [2]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$60 Copay	$55 Copay
Ambulance Services (per trip)	$325 Copay	$350 Copay	$325 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 70% (up to $250 per prescription [10]) (prior auth. required) [5, 7]	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 70% (up to $250 per prescription [10]) (prior auth. required) [5, 7]	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 70% (up to $250 per prescription [10]) (prior auth. required) [5, 7]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [5, 7]	Applicable Rx Copay [5, 7]	Applicable Rx Copay [5, 7]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3]	100% [3]	100% [3]
Chronic Disease Management	$50 Copay	$60 Copay	$55 Copay
Chemotherapy	$30 Copay	$40 Copay	$35 Copay
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$15 Copay [1]	$15 Copay [1]	$15 Copay [1]
Physical, Occupational, Speech Therapy	$30 Copay [6]	$40 Copay [6]	$35 Copay [6]
Rehabilitative & Habilitative Services and Devices	$30 Copay [6]	$40 Copay [6]	$35 Copay [6]
Home Health Care (Max 100 visits per year)	$30 Copay	$40 Copay	$35 Copay

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	60%	70%
Mental Health			
In-Patient	$750 Copay per day – 4 days max [4]	$750 Copay per day – 5 days max [4]	$750 Copay per day – 4 days max [4]
Out-Patient (office visit)	$30 Copay [4]	$40 Copay [4]	$35 Copay [4]
Drug/Substance Abuse			
In-Patient (Detox Only)	$750 Copay per day – 4 days max	$750 Copay per day – 5 days max	$750 Copay per day – 4 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	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

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

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

Gold HMO

Groups Beginning 4.1.2025

Services	HMO D	HMO E	HMO G
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Salud HMO y Mas	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [1]	$7,350 / $14,700	$7,250 / $14,500
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$35 Copay	$30 Copay
Specialist Visit (SPC)	$55 Copay	$55 Copay	$50 Copay
Laboratory	$40 Copay	$40 Copay	$40 Copay
X-Ray	$50 Copay	$50 Copay	$40 Copay
MRI, CT and PET (office setting)	$325 Copay per procedure	$325 Copay per procedure	$325 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$750 Copay per day – 4 days max	$750 Copay per day – 4 days max	$750 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$325 Copay	$325 Copay	$325 Copay
Urgent Care	$35 Copay	$35 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $1,200 Copay $480 Copay [2]	 $1,200 Copay $480 Copay [2]	 $900 Copay $360 Copay [2]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$55 Copay	$50 Copay
Ambulance Services (per trip)	$325 Copay	$325 Copay	$325 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [3, 6] $50 Copay [3, 6] $70 Copay [3, 6] 70% (up to $250 per prescription [11]) (prior auth. required) [3, 6]	 $15 Copay [3, 6] $50 Copay [3, 6] $70 Copay [3, 6] 70% (up to $250 per prescription [11]) (prior auth. required) [3, 6]	 $20 Copay [3, 6] $50 Copay [3, 6] $70 Copay [3, 6] 70% (up to $250 per prescription [11]) prior auth. required) [3, 6]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [3, 6]	Applicable Rx Copay [3, 6]	Applicable Rx Copay [3, 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% [5]	100% [5]	100% [5]
Chronic Disease Management	$55 Copay	$55 Copay	$50 Copay
Chemotherapy	$35 Copay	$35 Copay	$30 Copay
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$15 Copay [4]	$15 Copay [4]	$15 Copay [4]
Physical, Occupational, Speech Therapy	$35 Copay [7]	$35 Copay [7]	$30 Copay [7]
Rehabilitative & Habilitative Services and Devices	$35 Copay [7]	$35 Copay [7]	$30 Copay [7]
Home Health Care (Max 100 visits per year)	$35 Copay	$35 Copay	$30 Copay

Gold HMO

Groups Beginning 4.1.2025

Services	HMO D	HMO E	HMO G
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Salud HMO y Mas	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	70%	70%
Mental Health			
In-Patient	$750 Copay per day – 4 days max [10]	$750 Copay per day – 4 days max [10]	$750 Copay per day – 4 days max [10]
Out-Patient (office visit)	$35 Copay [10]	$35 Copay [10]	$30 Copay [10]
Drug/Substance Abuse			
In-Patient (Detox Only)	$750 Copay per day – 4 days max	$750 Copay per day – 4 days max	$750 Copay per day – 4 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	EyeMed [8]	EyeMed [8]	EyeMed [8]
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

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. 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.
2. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
3. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
4. Must be medically necessary.
5. See plan specific EOC for information on preventive 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. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Pediatric dental and vision are included on all plans.
9. 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.
10. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
11. Maximum member responsibility.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO H	HMO I	HMO B
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	SmartCare	SmartCare	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$250 / $500[16] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700	$7,500 / $15,000	$7,800 / $15,600[17]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$40 Copay	$35 Copay (ded waived)
Specialist Visit (SPC)	$55 Copay	$60 Copay	$55 Copay (ded waived)
Laboratory	$40 Copay	$40 Copay	$35 Copay (ded waived)
X-Ray	$50 Copay	$50 Copay	$55 Copay (ded waived)
MRI, CT and PET (office setting)	$325 Copay per procedure	$350 Copay per procedure	$250 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100% (ded waived)
Hospital Services – In-Patient	$750 Copay per day - 4 days max	$750 Copay per day - 5 days max	$600 Copay per day – 5 days max
In-Patient Physician Fees	100%	100%	100% (ded waived)
Emergency Room (copay waived if admitted)	$325 Copay	$350 Copay	$250 Copay
Urgent Care	$35 Copay	$40 Copay	$35 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $1,200 Copay $480 Copay[9]	 $1,200 Copay $480 Copay[9]	 $335 Copay per procedure $335 Copay per procedure
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$60 Copay	$55 Copay (ded waived)
Ambulance Services (per trip)	$325 Copay	$350 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay[3,6] $50 Copay[3,6] $70 Copay[3,6] 70% (up to $250 per prescription[8]) (prior auth. required)[3,6]	 $15 Copay[3,6] $50 Copay[3,6] $70 Copay[3,6] 70% (up to $250 per prescription[8]) (prior auth. required)[3,6]	 $15 Copay (overall ded waived) $40 Copay (overall ded waived) $40 Copay (overall ded waived) (with physician approval) 80% (up to $250 per prescription[8]) (overall ded waived) (with physician approval)
Oral Contraceptives	100%	100%	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay[3,6]	Applicable Rx Copay[3,6]	$40 Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100%[5]	100%[5]	100% (ded waived)[5]
Chronic Disease Management	$55 Copay	$60 Copay	Covered as any Illness
Chemotherapy	$35 Copay	$40 Copay	80% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$15 Copay[4]	$15 Copay[4]	$35 Copay (ded waived)
Physical, Occupational, Speech Therapy	$35 Copay[7]	$40 Copay[7]	$35 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$35 Copay[7]	$40 Copay[7]	$35 Copay (ded waived)

Gold HMO

Groups Beginning 4.1.2025

Services	HMO H	HMO I	HMO B
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	SmartCare	SmartCare	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	$35 copay	$40 Copay	$30 Copay (ded waived) [12]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$300 Copay per day – 5 days max
Hospice (out-patient)	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	70%	60%	80% [11, 18]
Mental Health In-Patient Out-Patient (office visit)	 $750 Copay per day – 4 days max [10] $35 Copay [10]	 $750 Copay per day – 5 days max [10] $40 Copay [10]	 $600 Copay per day – 5 days max $35 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	$750 Copay per day - 4 days max	$750 Copay per day – 5 days max	$600 Copay per day – 5 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [2] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [2] EyeMed 100% 100% 1 pair per calendar year None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [15] 1 pair per calendar year (ded waived) [15] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [1,2] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [1,2] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $40 Copay [13] $365 Copay [14] $350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. 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.
2. Pediatric dental and vision are included on all plans.
3. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
4. Must be medically necessary.
5. See plan specific EOC for information on preventive 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. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Maximum member responsibility.
9. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
10. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
11. Supplemental Durable Medical Equipment has a $2,000 annual maximum.
12. 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).
13. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
14. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
15. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
16. 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.
17. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
18. 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.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO C	HMO D	HMO E† HSA Qualified
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$1,000 / $2,000 [6] (applies to Max OOP)	$1,750 / $3,300 / $3,500 [6, 12] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,700 / $15,400 [7]	$8,200 / $16,400 [7]	$4,000 / $8,000 [7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$40 Copay (ded waived)	85%
Specialist Visit (SPC)	$60 Copay	$60 Copay (ded waived)	85%
Laboratory	$30 Copay	$30 Copay (ded waived)	85%
X-Ray	$40 Copay	$60 Copay (ded waived)	85%
MRI, CT and PET (office setting)	$250 Copay per procedure	$350 Copay per procedure	85% per procedure
Virtual/Telemedicine Office Visit	100%	100% (ded waived)	100%
Hospital Services – In-Patient	$600 Copay per day – 5 days max	$600 Copay per day – 5 days max	85%
In-Patient Physician Fees	100%	100% (ded waived)	85%
Emergency Room (copay waived if admitted)	$350 Copay	$350 Copay (ded waived)	85%
Urgent Care	$35 Copay	$40 Copay (ded waived)	85%
Hospital Services – Out-Patient			
Surgical Facility	$320 Copay per procedure	$350 Copay per procedure (ded waived)	85%
Ambulatory Surgery Center	$320 Copay per procedure	$350 Copay per procedure (ded waived)	85%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay	$60 Copay (ded waived)	85%
Ambulance Services (per trip)	$250 Copay	$350 Copay (ded waived)	85%
Rx Benefits			
Generic	$15 Copay	$20 Copay (ded waived)	$15 Copay (combined Med/Rx ded)
Formulary Brand	$50 Copay	$250 / $500 Ded – $50 Copay	$45 Copay (combined Med/Rx ded)
Non-Formulary Brand	$50 Copay (with physician approval)	$250 / $500 Ded - $50 Copay (with physician approval)	$45 Copay (combined Med/Rx ded) (with physician approval)
Specialty	80% (up to $250 per prescription [10]) (with physician approval)	$250 / $500 Ded - 80% (up to $250 per prescription [10]) (with physician approval)	85% (up to $250 per prescription [11]) (combined Med/Rx ded) (with physician approval)
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$50 Copay	$250 / $500 Ded - $50 Copay	$45 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% [5]	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	100% (ded waived)	85%
Chiropractic (20 visits max per year)	$15 Copay [4]	$15 Copay (ded waived) [4]	Not Covered
Acupuncture	$35 Copay [4]	$40 Copay (ded waived) [4]	85%
Physical, Occupational, Speech Therapy	$35 Copay	$40 Copay (ded waived)	85%
Rehabilitative & Habilitative Services and Devices	$35 Copay	$40 Copay (ded waived)	85%

Gold HMO

Groups Beginning 4.1.2025

Services	HMO C	HMO D	HMO E† HSA Qualified
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	100% [1]	100% (ded waived) [1]	85% [1]
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	85%
Hospice (out-patient)	100%	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	80% [8, 11]	80% [8, 11]	85% [8, 11]
Mental Health			
In-Patient	$600 Copay per day – 5 days max	$600 Copay per day – 5 days max	85%
Out-Patient (office visit)	$35 Copay	$40 Copay (ded waived)	85%
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day – 5 days max	$600 Copay per day – 5 days max	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	Kaiser Permanente	Kaiser Permanente
Network	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Exam	100%	100% (ded waived)	100% (ded waived)
Contact Lenses	1 pair per calendar year [9]	1 pair per calendar year [9]	1 pair per calendar year [9]
Frames	1 pair per calendar year [9]	1 pair per calendar year (ded waived) [9]	1 pair per calendar year (ded waived) [9]
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700	$350 / $700
Office Visit	100%	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100%	100% (ded waived)	100% (ded waived)
Basic Services	$40 Copay [2]	$40 Copay [2]	$40 Copay [2]
Major Services (no waiting period)	$365 Copay [3]	$365 Copay [3]	$365 Copay [3]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* 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. 20 visits max per year combined for Chiropractic and Acupuncture.
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. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
10. Maximum member responsibility.
11. Supplemental Durable Medical Equipment has a $2,000 annual maximum.
12. $1,750 Self only enrollment, $3,300 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO D
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sharp Health Plan
Network Name	Performance	Premier	Performance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$9,200 / $18,400 [3]	$9,200 / $18,400 [3]	$9,150 / $18,300 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$40 Copay	$35 Copay
Specialist Visit (SPC)	$50 Copay	$60 Copay	$55 Copay
Laboratory	$15 Copay	$15 Copay	$15 Copay
X-Ray	$20 Copay	$60 Copay	$55 Copay
MRI, CT and PET (office setting)	$275 Copay	$250 Copay	$175 Copay
Virtual/Telemedicine Office Visit	Covered as any Illness	Covered as any Illness	Covered as any Illness
Hospital Services – In-Patient	70%	$600 Copay per day – 5 days max	$1,500 Copay
In-Patient Physician Fees	70%	100%	100%
Emergency Room (copay waived if admitted)	70%	$400 Copay	$300 Copay
Urgent Care	$50 Copay	$60 Copay	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 75% 75%	 $600 Copay $600 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$60 Copay	$55 Copay
Ambulance Services (per trip)	70%	$200 Copay	$200 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $16 Copay (ded waived) $250 / $500 Ded – $35 Copay $250 / $500 Ded – $70 Copay $250 / $500 Ded – Applicable Rx Copay	 $16 Copay (ded waived) $500 / $1,000 Ded – $45 Copay $500 / $1,000 Ded – $75 Copay $500 / $1,000 Ded – Applicable Rx Copay	 $16 Copay $35 Copay $70 Copay Applicable Rx Copay
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100% (if in formulary)
Diabetes – Self-Injectable	$250 / $500 Ded – Applicable Rx Copay	$500 / $1,000 Ded – Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	70% [9]	$600 Copay per day – 5 days max [9]	$1,500 Copay [9]
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	$50 Copay	$60 Copay	$55 Copay
Chemotherapy	Variable [6]	Variable [6]	Variable [6]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$20 Copay	$40 Copay	$35 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$40 Copay	$35 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$40 Copay	$35 Copay

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO D
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sharp Health Plan
Network Name	Performance	Premier	Performance
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	$20 Copay	$40 Copay	$35 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	$25 Copay per day	$175 Copay
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 70% $20 Copay	 $150 Copay per day – 5 days max $40 Copay	 $750 Copay $35 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 70%	 $150 Copay per day – 5 days max	 $750 Copay
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP Advantage Network 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 of California Delta Dental DeltaCare USA None Combined with Medical 100% [5] 100% [8] $25 Copay [7] $300 Copay [2] $1,000 Copay [1]	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [5] 100% [8] $25 Copay [7] $300 Copay [2] $1,000 Copay [1]	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [5] 100% [8] $25 Copay [7] $300 Copay [2] $1,000 Copay [1]

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. Refers to procedure code D8080/D8090
2. Refers to procedure code D3330
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. Refers to procedure code D0999
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Refers to procedure code D2140
8. Refers to procedure codes D0120 and D1120/D1110
9. Amount listed for In-Patient Services only.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	Sutter Health Plan	Sutter Health Plan	Sutter Health Plan
Network Name	Sutter Health Plan	Sutter Health Plan	Sutter Health Plan
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,500 / $3,000 [2] (applies to Max OOP)	$250 / $500 [2] (applies to Max OOP)	$1,650 / $3,300 / $ 3,300 [2, 4] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000 [6]	$7,800 / $15,600 [6]	$6,000 / $12,000 [6]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay [7]	$35 Copay (ded waived) [7]	80% [7]
Specialist Visit (SPC)	$50 Copay	$55 Copay (ded waived)	80%
Laboratory	$30 Copay	$35 Copay (ded waived)	80%
X-Ray	$50 Copay per procedure	$55 Copay per procedure (ded waived)	80%
MRI, CT and PET (office setting)	$175 Copay per procedure	$250 Copay per procedure	80%
Virtual/Telemedicine Office Visit	Variable [9]	Variable [9]	Variable [9]
Hospital Services – In-Patient	80%	$600 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	80%	100% (ded waived)	80%
Emergency Room (copay waived if admitted)	$200 Copay	$250 Copay	80%
Urgent Care	$30 Copay	$35 Copay (ded waived)	80%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 $300 Copay $300 Copay	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$55 Copay (ded waived)	80%
Ambulance Services (per trip)	$200 Copay	$250 Copay	80%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (overall ded waived) [8] $30 Copay (overall ded waived) [8] $50 Copay (overall ded waived) [8] 80% (up to $250 per prescription [5]) (overall ded waived) [8]	 $15 Copay (overall ded waived) [8] $40 Copay (overall ded waived) [8] $70 Copay (overall ded waived) [8] 80% (up to $250 per prescription [5]) (overall ded waived) [8]	 $15 Copay (combined Med/Rx ded) [8] $50 Copay (combined Med/Rx ded) [8] $80 Copay (combined Med/Rx ded) [8] 80% (up to $250 per prescription [5]) (combined Med/Rx ded) [8]
Oral Contraceptives	100% (overall ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) [8]	Applicable Rx Copay (overall ded waived) [8]	Applicable Rx Copay (combined Med/Rx ded) [8]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	80%	80% (ded waived)	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$30 Copay	$35 Copay (ded waived)	80%
Physical, Occupational, Speech Therapy	$30 Copay	$35 Copay (ded waived)	80%
Rehabilitative & Habilitative Services and Devices	$30 Copay	$35 Copay (ded waived)	80%

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C † HSA Qualified
Participating Health Plans	Sutter Health Plus	Sutter Health Plus	Sutter Health Plus
Network Name	Sutter Health Plus	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	80%	$30 Copay (ded waived)	80%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	$300 Copay per day – 5 days max per admit	80%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	80%	80% (ded waived)	80%
Mental Health			
In-Patient	80% [3]	$600 Copay per day – 5 days max per admit [3]	80% [3]
Out-Patient (office visit)	$30 Copay	$35 Copay (ded waived)	80%
Drug/Substance Abuse			
In-Patient (Detox Only)	80% [3]	$600 Copay per day – 5 days max per admit [3]	80% [3]
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	Choice Network	Choice Network	Choice Network
Exam	100% (ded waived) [10]	100% (ded waived) [10]	100% (ded waived) [10]
Contact Lenses	100% (in lieu of eyeglasses) (ded waived) [10, 11]	100% (in lieu of eyeglasses) (ded waived) [10, 11]	100% (in lieu of eyeglasses) (ded waived) [10, 11]
Frames	100% (in lieu of contact lenses) (ded waived) [10, 11]	100% (in lieu of contact lenses) (ded waived) [10, 11]	100% (in lieu of contact lenses) (ded waived) [10, 11]
Maximum Allowance per year	1 pair per year	1 pair per year	1 pair per year
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service (ded waived)	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	Copay varies by service (ded waived)	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Major Services (no waiting period)	Copay varies by service (ded waived)	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Orthodontics (medically necessary)	$1,000 Copay (ded waived)	$1,000 Copay (ded waived)	$1,000 Copay (ded waived)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. See plan specific EOC for information on preventive services.
2. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plan pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plan pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plan pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,300 for 2025 plans.
3. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for autism spectrum disorder.
4. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
5. Maximum member responsibility.
6. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
7. Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk-in Care visits.
8. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be up to four times the retail cost share. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
9. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.
10. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
11. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every calendar year.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO F
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	SignatureValue
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,250 / $2,500 [6] (applies to Max OOP)	$1,250 / $2,500 [6] (applies to Max OOP)	None
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [1]	$6,750 / $13,500 [1]	$7,500 / $15,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay
Specialist Visit (SPC)	$70 Copay (ded waived)	$70 Copay (ded waived)	$70 Copay
Laboratory	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay
X-Ray	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay
MRI, CT and PET (office setting)	$300 Copay per procedure (ded waived)	$300 Copay per procedure (ded waived)	$300 Copay per procedure
Virtual/Telemedicine Office Visit	100% (ded waived)	100% (ded waived)	100%
Hospital Services – In-Patient	75%	75%	$700 Copay per day – 5 days max per admit
In-Patient Physician Fees	75% (ded waived)	75% (ded waived)	100%
Emergency Room (copay waived if admitted)	$500 Copay	$500 Copay	$500 Copay
Urgent Care	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 75% 75%	 75% 75%	 $500 Copay $500 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$70 Copay (ded waived)	$70 Copay (ded waived)	$70 Copay
Ambulance Services (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [7] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [7] $100 / $200 Ded – Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay [7] $100 / $200 Ded – Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [7] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [7] $100 / $200 Ded – Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay [7] $100 / $200 Ded – Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [7] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [7] Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay [7] Tier 4 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay	Applicable Ded / 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% (ded waived) [4]	100% (ded waived) [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay (ded waived) [5]	$150 Copay (ded waived) [5]	$150 Copay [5]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay
Acupuncture	$10 Copay (ded waived)	$10 Copay (ded waived)	$10 Copay
Physical, Occupational, Speech Therapy	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay
Rehabilitative & Habilitative Services and Devices	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO F
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	SignatureValue
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	75%	75%	$300 per day - 5 days max per admit
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay (ded waived)	$70 Copay (ded waived)	$70 Copay
Mental Health In-Patient Out-Patient (office visit)	 75% $35 Copay (ded waived)	 75% $35 Copay (ded waived)	 $600 Copay per day - 4 days max per admit $35 Copay
Drug/Substance Abuse In-Patient (Detox Only)	75%	75%	$600 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)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% (ded waived) 75% (ded waived) 75% (ded waived) 1 per calendar year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% (ded waived) 75% (ded waived) 75% (ded waived) 1 per calendar year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% 90% 90% 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 $350 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $350 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† HSA Qualified High Deductible Plan

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

1. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
7. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO G	HMO H	HMO J
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$500 / $1,000[1] (applies to Max OOP)	$500 / $1,000[1] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000[2]	$8,000 / $16,000[2]	$8,000 / $16,000[2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$35 Copay (ded waived)	$35 Copay (ded waived)
Specialist Visit (SPC)	$70 Copay	$70 Copay (ded waived)	$70 Copay (ded waived)
Laboratory	$40 Copay	$40 Copay (ded waived)	$40 Copay (ded waived)
X-Ray	$40 Copay	$40 Copay (ded waived)	$40 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay per procedure	$300 Copay per procedure (ded waived)	$300 Copay per procedure (ded waived)
Virtual/Telemedicine Office Visit	100%	100% (ded waived)	100% (ded waived)
Hospital Services – In-Patient	$700 Copay per day – 5 days max per admit	80%	80%
In-Patient Physician Fees	100%	80% (ded waived)	80% (ded waived)
Emergency Room (copay waived if admitted)	$500 Copay	$500 Copay	$500 Copay
Urgent Care	$100 Copay	$100 Copay (ded waived)	$100 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $500 Copay	 80% 80%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$70 Copay	$70 Copay (ded waived)	$70 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay	$100 Copay (ded waived)	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay[7] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay[7] Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay[7] Tier 4 75% (up to $250 per prescription[4])[3]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived)[7] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay[7] $100 / $200 Ded – Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay[7] $100 / $200 Ded – Tier 4 75% (up to $250 per prescription[4])[3]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived)[7] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay[7] $100 / $200 Ded – Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay[7] $100 / $200 Ded – Tier 4 75% (up to $250 per prescription[4])[3]
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Ded / Rx Copay	Applicable Ded / Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100%[5]	100% (ded waived)[5]	100% (ded waived)[5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay[6]	$150 Copay (ded waived)[6]	$150 Copay (ded waived)[6]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay (ded waived)	$15 Copay (ded waived)
Acupuncture	$10 Copay	$10 Copay (ded waived)	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$35 Copay	$35 Copay (ded waived)	$35 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$35 Copay	$35 Copay (ded waived)	$35 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$35 Copay	$35 Copay (ded waived)	$35 Copay (ded waived)

Gold HMO

Groups Beginning 4.1.2025

Services	HMO G	HMO H	HMO J
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 per day - 5 days max per admit	80%	80%
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay (ded waived)	$70 Copay (ded waived)
Mental Health			
In-Patient	$600 Copay per day - 4 days max per admit	80%	80%
Out-Patient (office visit)	$35 Copay	$35 Copay (ded waived)	$35 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day - 4 days max per admit	80%	80%
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	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100%	100% (ded waived)	100% (ded waived)
Contact Lenses	90%	80% (ded waived)	80% (ded waived)
Frames	90%	80% (ded waived)	80% (ded waived)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	CA DHMO	CA DHMO	CA DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100%	100% (ded waived)	100% (ded waived)
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)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. 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.
2. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. No change to how Specialty Drugs in Tier 4 are filled today.
4. Maximum member responsibility.
5. See plan specific EOC for information on preventive services.
6. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
7. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO L	HMO M	HMO N
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Harmony	Harmony	Harmony
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,250 / $2,500[1] (applies to Max OOP)	None	$500 / $1,000[1] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500[2]	$7,500 / $15,000[2]	$8,000 / $16,000[2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay (ded waived)	$35 Copay	$35 Copay (ded waived)
Specialist Visit (SPC)	$70 Copay (ded waived)	$70 Copay	$70 Copay (ded waived)
Laboratory	$40 Copay (ded waived)	$40 Copay	$40 Copay (ded waived)
X-Ray	$40 Copay (ded waived)	$40 Copay	$40 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay per procedure (ded waived)	$300 Copay per procedure	$300 Copay per procedure (ded waived)
Virtual/Telemedicine Office Visit	100% (ded waived)	100%	100% (ded waived)
Hospital Services – In-Patient	75%	$700 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	75% (ded waived)	100%	80% (ded waived)
Emergency Room (copay waived if admitted)	$500 Copay	$500 Copay	$500 Copay
Urgent Care	$100 Copay (ded waived)	$100 Copay	$100 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 75% 75%	 $500 Copay $500 Copay	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$70 Copay (ded waived)	$70 Copay	$70 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	$100 Copay	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived)[7] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay[7] $100 / $200 Ded – Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay[7] $100 / $200 Ded – Tier 4 75% (up to $250 per prescription[4])[3]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay[7] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay[7] Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay[7] Tier 4 75% (up to $250 per prescription[4])[3]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived)[7] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay[7] $100 / $200 Ded – Tier 3 Non-specialty $100 Copay / Tier 3 Specialty $250 Copay[7] $100 / $200 Ded – Tier 4 75% (up to $250 per prescription[4])[3]
Oral Contraceptives	100% (ded waived)	100%	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay	Applicable Rx Copay	Applicable Ded / Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[5]	100%[5]	100% (ded waived)[5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay (ded waived)[6]	$150 Copay[6]	$150 Copay (ded waived)[6]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay	$15 Copay (ded waived)
Acupuncture	$10 Copay (ded waived)	$10 Copay	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$35 Copay (ded waived)	$35 Copay	$35 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$35 Copay (ded waived)	$35 Copay	$35 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$35 Copay (ded waived)	$35 Copay	$35 Copay (ded waived)

Gold HMO

Groups Beginning 4.1.2025

Services	HMO L	HMO M	HMO N
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Harmony	Harmony	Harmony
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	75%	$300 Copay per day – 5 days max per admit	80%
Hospice (out-patient)	100% (ded waived)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$70 Copay (ded waived)	$70 Copay	$70 Copay (ded waived)
Mental Health			
In-Patient	75%	$600 Copay per day – 4 days max per admit	80%
Out-Patient (office visit)	$35 Copay (ded waived)	$35 Copay	$35 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	75%	$600 Copay per day – 4 days max per admit	80%
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	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100% (ded waived)	100%	100% (ded waived)
Contact Lenses	75% (ded waived)	90%	80% (ded waived)
Frames	75% (ded waived)	90%	80% (ded waived)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	CA DHMO	CA DHMO	CA DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100% (ded waived)	100%	100% (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100%	100% (ded waived)
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)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. 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.
2. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. No change to how Specialty Drugs in Tier 4 are filled today.
4. Maximum member responsibility.
5. See plan specific EOC for information on preventive services.
6. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
7. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO O	HMO P	HMO Q
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	SignatureValue
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000 [2]	$7,500 / $15,000 [2]	$7,500 / $15,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$35 Copay	$35 Copay
Specialist Visit (SPC)	$70 Copay	$70 Copay	$70 Copay
Laboratory	$40 Copay	$40 Copay	$40 Copay
X-Ray	$40 Copay	$40 Copay	$40 Copay
MRI, CT and PET (office setting)	$200 Copay per procedure	$200 Copay per procedure	$200 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$400 Copay	$400 Copay	$400 Copay
Urgent Care	$100 Copay	$100 Copay	$100 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $400 Copay $400 Copay	 $400 Copay $400 Copay	 $400 Copay $400 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$70 Copay	$70 Copay	$70 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$70 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [1] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [1] Tier 3 Non-specialty $85 Copay / Tier 3 Specialty $250 Copay [1] Tier 4 75% (up to $250 per prescription [4]) [3]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [1] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [1] Tier 3 Non-specialty $85 Copay / Tier 3 Specialty $250 Copay [1] Tier 4 75% (up to $250 per prescription [4]) [3]	 Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [1] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [1] Tier 3 Non-specialty $85 Copay / Tier 3 Specialty $250 Copay [1] Tier 4 75% (up to $250 per prescription [4]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx 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	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [6]	$150 Copay [6]	$150 Copay [6]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$35 Copay	$35 Copay	$35 Copay
Rehabilitative & Habilitative Services and Devices	$35 Copay	$35 Copay	$35 Copay
Home Health Care (Max 100 visits per year)	$35 Copay	$35 Copay	$35 Copay

Gold HMO

Groups Beginning 4.1.2025

Services	HMO O	HMO P	HMO Q
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	SignatureValue
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day - 4 days max per admit	$300 Copay per day - 4 days max per admit	$300 Copay per day - 4 days max per admit
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	$70 Copay
Mental Health			
In-Patient	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit
Out-Patient (office visit)	$35 Copay	$35 Copay	$35 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit
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	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100%	100%	100%
Contact Lenses	90%	90%	90%
Frames	90%	90%	90%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	CA DHMO	CA DHMO	CA DHMO
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)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.
2. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. No change to how Specialty Drugs in Tier 4 are filled today.
4. Maximum member responsibility.
5. See plan specific EOC for information on preventive services.
6. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
7. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$250 / $500 [1, 3] (applies to Max OOP)	$1,000 / $2,000 [1, 3] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000 [2]	$7,800 / $15,600 [2, 3]	$7,800 / $15,600 [2, 3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay	$35 Copay (ded waived)	$40 Copay (ded waived)
Specialist Visit (SPC)	$40 Copay	$55 Copay (ded waived)	$40 Copay (ded waived)
Laboratory	$40 Copay	$35 Copay (ded waived)	100% (ded waived)
X-Ray	$40 Copay	$55 Copay (ded waived)	$40 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay	$250 Copay [1]	$300 Copay (ded waived)
Virtual/Telemedicine Office Visit	Variable [4]	Variable [4]	Variable [13]
Hospital Services – In-Patient	$600 Copay per day	$600 Copay per day [1] – Days 1-5	$500 Copay per day [1] – Days 1-5
In-Patient Physician Fees	100%	100% (ded waived)	100% (ded waived)
Emergency Room (copay waived if admitted)	$300 Copay	$250 Copay [1]	$300 Copay [1]
Urgent Care	$100 Copay	$35 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay $300 Copay	 $300 Copay [1] $300 Copay [1]	 $500 Copay [1] $500 Copay [1]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$55 Copay (ded waived)	$40 Copay (ded waived)
Ambulance Services (per trip)	100%	$250 Copay [1]	100% (ded waived)
Rx Benefits Generic	 $20 Copay	 $15 Copay (overall ded waived)	 $10 Copay (ded waived)
Formulary Brand	$50 Copay [6]	$40 Copay (overall ded waived) [6]	$500 / $1,000 Ded – $50 Copay [1, 6]
Non-Formulary Brand	$75 Copay [6]	$70 Copay (overall ded waived) [6]	$500 / $1,000 Ded – $75 Copay [1, 6]
Specialty	80% (up to $250 per 30 day supply [11]) [5]	80% (up to $250 per 30 day supply [11]) (overall ded waived) [5]	$500 / $1,000 Ded – 80% (up to $250 per 30 day supply [3, 7]) [1, 5]
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$50 Copay	$40 Copay (overall ded waived)	$500 / $1,000 Ded – $50 Copay [1]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [7, 12]	100% (ded waived) [7, 12]	100% (ded waived) [7, 12]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	80% (ded waived) [5]	100% (ded waived)
Chiropractic (20 visits max per year)	$15 Copay [8]	$15 Copay (ded waived) [8]	$15 Copay (ded waived) [8]
Acupuncture	$15 Copay	$15 Copay (ded waived)	$15 Copay (ded waived)
Physical, Occupational, Speech Therapy	$40 Copay	$35 Copay (ded waived)	$40 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$40 Copay	$35 Copay (ded waived)	$40 Copay (ded waived)
Home Health Care (Max 100 visits per year)	100%	$30 Copay (ded waived)	100% (ded waived)

Gold HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$600 Copay per day	$300 Copay per day[1] – Days 1-5	$500 Copay per day[1] – Days 1-5
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80%[5, 9]	80% (ded waived)[5, 9]	80% (ded waived)[5, 9]
Mental Health			
In-Patient	$600 Copay per day	$600 Copay per day[1] – Days 1-5	$500 Copay per day[1] – Days 1-5
Out-Patient (office visit)	$40 Copay	$35 Copay (ded waived)	$40 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	$600 Copay per day	$600 Copay per day[1] – Days 1-5	$500 Copay per day[1] – Days 1-5
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	EyeMed	EyeMed	EyeMed
Network	Eyewear Only	Eyewear Only	Eyewear Only
Exam	100%	100% (ded waived)	100% (ded waived)
Contact Lenses	100%	100% (ded waived)	100% (ded waived)
Frames	100%	100% (ded waived)	100% (ded waived)
Maximum Allowance per year	1 per calendar year[10]	1 per calendar year[10]	1 per calendar year[10]
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay	$1,000 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* 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. 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.
4. Cost share amount varies based on type of services rendered.
5. Percentage copayment amounts are based on WHA's contracted rates with the provider of service or medication.
6. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or contribute to the out-of-pocket maximum.
7. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
8. Copayments do not contribute to out-of-pocket maximum.
9. See copayment summary for applicable prosthetic/orthotic device copayment amount.
10. Limited to one pair of glasses with standard lenses and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable contact lenses instead of glasses.
11. Maximum member responsibility.
12. See plan specific EOC for information on preventive services.

Gold HMO

Groups Beginning 4.1.2025

Services	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Gold**
Calendar Year Deductible*	$2,600 / $3,300 / $5,200 [1, 9, 11] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$4,800 / $9,600 [2, 11]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	100% [1]
Specialist Visit (SPC)	100% [1]
Laboratory	100% [1]
X-Ray	100% [1]
MRI, CT and PET (office setting)	100% [1]
Virtual/Telemedicine Office Visit	Variable [13]
Hospital Services – In-Patient	100% [1]
In-Patient Physician Fees	100% [1]
Emergency Room (copay waived if admitted)	100% [1]
Urgent Care	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% [1] 100% [1]
Hospital Pre-Authorization	Required
2nd Surgical Opinion	100% [1]
Ambulance Services (per trip)	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% (combined Med/Rx ded) [1] $40 Copay (combined Med/Rx ded) [1, 10] $60 Copay (combined Med/Rx ded) [1, 10] 80% (up to $250 per 30 day supply [7]) (combined Med/Rx ded) [1, 8]
Oral Contraceptives	100% (ded waived)
Diabetes – Self-Injectable	100% (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3,5]
Chronic Disease Management	Covered as any Illness
Chemotherapy	100% [1]
Chiropractic (20 visits max per year)	100% [1, 12]
Acupuncture	100% [1]
Physical, Occupational, Speech Therapy	100% [1]
Rehabilitative & Habilitative Services and Devices	100% [1]
Home Health Care (Max 100 visits per year)	100% [1]

Gold HMO

Groups Beginning 4.1.2025

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

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† 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 and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable contact lenses instead of glasses.
7. Maximum member responsibility.
8. Percentage copayment amounts are based on WHA's contracted rates with the provider of service or medication.
9. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
10. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or contribute to the out-of-pocket maximum.
11. 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.
12. Copayments do not contribute to out-of-pocket maximum.
13. Cost share amount varies based on type of services rendered.

Gold PPO

Groups Beginning 4.1.2025

Services	PPO B		PPO C	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$1,000 / $3,000 (applies to Max OOP)	$2,000 / $4,000 (applies to Max OOP)	$500 / $1,500 (applies to Max OOP)	$2,000 / $4,000 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [1]	$15,600 / $31,200 [1]	$7,700 / $15,400 [1]	$15,400 / $30,800 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$25 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Specialist Visit (SPC)	$50 Copay (ded waived)	50%	$60 Copay (ded waived)	50%
Laboratory	$15 Copay (ded waived)	50%	$15 Copay (ded waived)	50%
X-Ray	$15 Copay (ded waived)	50%	$15 Copay (ded waived)	50%
MRI, CT and PET (office setting)	75% [14]	50% (up to $800 per test) [5]	80% [14]	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	$25 Copay / $50 Copay (ded waived) [15]	50%	$30 Copay / $60 Copay (ded waived) [15]	50%
Hospital Services –In-Patient	75%	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	75%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 75%		$250 Copay – 80%	
Urgent Care	$25 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit - 75% $50 Copay per admit - 75%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit - 80% $50 Copay per admit - 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$50 Copay (ded waived)	50%	$60 Copay (ded waived)	50%
Ambulance Services (per trip)	75% [13]		80% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [2] $250 / $500 Ded – Level 1 $50 Copay / Level 2 $60 Copay [2] $250 / $500 Ded – Level 1 $90 Copay / Level 2 $100 Copay [2] $250 / $500 Ded – Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived) [2] Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived) [2] Level 1 $90 Copay / Level 2 $100 Copay (overall ded waived) [2] Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (overall ded waived) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered	Applicable 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 [16]		Covered [16]	
Chemotherapy	75%	50% [14]	80%	50% [14]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered

Gold PPO

Groups Beginning 4.1.2025

Services	PPO B		PPO C	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Acupuncture	$25 Copay (ded waived)	Not Covered	$30 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$25 Copay (ded waived)	50% [14]	$30 Copay (ded waived)	50% [14]
Rehabilitative & Habilitative Services and Devices	$25 Copay (ded waived) [11]	50% [11]	$30 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	75% (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)	75% [12]	50% (up to $150 per day) [5, 12]	80% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)		50%		50%
Mental Health In-PatientOut-Patient (office visit)	 75% $25 Copay (ded waived)	 50% (up to $650 per day) [5] 50%	 80% $30 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 75%	 50% (up to $650 per day) [5]	 80%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $25 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $30 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime None Combined with Medical (IN & OON) 100% 100% 80% 50% 50%	 Anthem Dental None Combined with Medical (IN & OON) 100% 100% 80% 50% 50%	 Anthem Dental Prime None Combined with Medical (IN & OON) 100% 100% 80% 50% 50%	 Anthem Dental None Combined with Medical (IN & OON) 100% 100% 80% 50% 50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

(Footnotes continued on page 85)

Gold PPO

Groups Beginning 4.1.2025

Services	PPO D		PPO E	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Prudent Buyer – Small Group	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$1,500 / $3,000 (applies to Max OOP)	$3,000 / $6,000 (applies to Max OOP)	$500 / $1,500 (applies to Max OOP)	$2,000 / $4,000 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,600 / $13,200 [1]	$13,200 / $26,400 [1]	$7,700 / $15,400 [1]	$15,400 / $30,800 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Specialist Visit (SPC)	$60 Copay (ded waived)	50%	$60 Copay (ded waived)	50%
Laboratory	$15 Copay (ded waived)	50%	$15 Copay (ded waived)	50%
X-Ray	$15 Copay (ded waived)	50%	$15 Copay (ded waived)	50%
MRI, CT and PET (office setting)	75% [14]	50% (up to $800 per test) [5]	80% [14]	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	$30 Copay / $60 Copay (ded waived) [15]	50%	$30 Copay / $60 Copay (ded waived) [15]	50%
Hospital Services – In-Patient	75%	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	75%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 75%		$250 Copay – 80%	
Urgent Care	$30 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit - 75% $50 Copay per admit - 75%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit - 80% $50 Copay per admit - 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$60 Copay (ded waived)	50%	$60 Copay (ded waived)	50%
Ambulance Services (per trip)	75% [13]		80% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [2] $250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay [2] $250 / $500 Ded - Level 1 $90 Copay / Level 2 $100 Copay [2] $250 / $500 Ded – Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived) [2] Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived) [2] Level 1 $90 Copay / Level 2 $100 Copay (overall ded waived) [2] Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (overall ded waived) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered	Applicable 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 [16]		Covered [16]	
Chemotherapy	75%	50% [14]	80%	50% [14]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$30 Copay (ded waived)	Not Covered	$30 Copay (ded waived)	Not Covered

Gold PPO

Groups Beginning 4.1.2025

Services	PPO D		PPO E	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Prudent Buyer - Small Group	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	50% [14]	$30 Copay (ded waived)	50% [14]
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived) [11]	50% [11]	$30 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	75% (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)	75% [12]	50% (up to $150 per day) [5, 12]	80% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health				
In-Patient	75%	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
Out-Patient (office visit)	$30 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	75%	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	$30 Copay (ded waived) [7]	50% [7]	$30 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	None	None	None	None
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%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

(Footnotes continued on page 85)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,200 / $4,400 [2] (applies to Max OOP)	$2,200 / $4,400 [2] (applies to Max OOP)	None
Out-of-Pocket Max Ind/Fam	$9,100 / $18,200 [3]	$9,100 / $18,200 [3]	$9,200 / $18,400
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	$60 Copay (ded waived)	$55 Copay
Specialist Visit (SPC)	$95 Copay (ded waived)	$95 Copay (ded waived)	$90 Copay
Laboratory	$20 Copay (ded waived) [12]	$20 Copay (ded waived) [12]	$40 Copay
X-Ray	$20 Copay (ded waived) [12]	$20 Copay (ded waived) [12]	$60 Copay
MRI, CT and PET (office setting)	$200 Copay (ded waived) [14]	$200 Copay (ded waived) [14]	$400 Copay per procedure
Virtual/Telemedicine Office Visit	$60 Copay / $95 Copay (ded waived) [15]	$60 Copay / $95 Copay (ded waived) [15]	100%
Hospital Services – In-Patient	55%	55%	$750 Copay per day - 5 days max
In-Patient Physician Fees	100% (ded waived)	100% (ded waived)	100%
Emergency Room (copay waived if admitted)	$350 Copay – 55%	$350 Copay – 55%	50%
Urgent Care	$60 Copay (ded waived)	$60 Copay (ded waived)	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 55% $600 Copay	 55% $600 Copay	 50% 60% [6]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$95 Copay (ded waived)	$95 Copay (ded waived)	$90 Copay
Ambulance Services (per trip)	55% [8]	55% [8]	50%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [9] $300 / $600 Ded – Level 1 $70 Copay / Level 2 $80 Copay [9] $300 / $600 Ded – Level 1 $110 Copay / Level 2 $120 Copay [9] $300 / $600 Ded – Level 1 70% / Level 2 60% (up to $250 per prescription [7])(prior auth. required) [5, 9]	 Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [9] $300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [9] $300 / $600 Ded - Level 1 $110 Copay / Level 2 $120 Copay [9] $300 / $600 Ded – Level 1 70% / Level 2 60% (up to $250 per prescription [7]) (prior auth. required) [5, 9]	 $20 Copay (ded waived) [18, 19] $500 / $1,000 Ded – 50% (up to $250 per prescription [7]) [18, 19] $500 / $1,000 Ded – 50% (up to $250 per prescription [7]) [18, 19] $500 / $1,000 Ded – 50% (up to $250 per prescription [7]) (prior auth. required) [18, 19]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [9]	Applicable Ded / Rx Copay [9]	$500 / $1,000 Ded – Applicable Rx Copay [18, 19]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% [1]
Chronic Disease Management	Covered [16]	Covered [16]	$90 Copay
Chemotherapy	55% (ded waived) [10]	55% (ded waived) [10]	$55 Copay
Chiropractic (20 visits max per year)	$15 Copay (ded waived) (30 visits max per benefit period) [11]	$15 Copay (ded waived) (30 visits max per benefit period) [11]	Not Covered
Acupuncture	$60 Copay (ded waived)	$60 Copay (ded waived)	$15 Copay [23]
Physical, Occupational, Speech Therapy	$60 Copay (ded waived) [12]	$60 Copay (ded waived) [12]	$55 Copay [20]

Silver HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived) [12]	$60 Copay (ded waived) [12]	$55 Copay [20]
Home Health Care (Max 100 visits per year)	$95 Copay (ded waived) (Max 100 visits per benefit period) [4]	$95 Copay (ded waived) (Max 100 visits per benefit period) [4]	$55 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	55% [13]	55% [13]	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health			
In-Patient	55%	55%	$750 Copay per day - 5 days max [17]
Out-Patient (office visit)	$60 Copay (ded waived)	$60 Copay (ded waived)	$55 Copay [17]
Drug/Substance Abuse			
In-Patient (Detox Only)	55%	55%	$750 Copay per day - 5 days max
Infertility			
Infertility Evaluation and Treatment	$60 Copay (ded waived) [6]	$60 Copay (ded waived) [6]	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	Anthem Vision	EyeMed [24]
Network	Blue View Vision	Blue View Vision	EyeMed
Exam	100% (ded waived)	100% (ded waived)	100%
Contact Lenses	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	100%
Frames	100% (ded waived)	100% (ded waived)	1 pair per calendar year
Maximum Allowance per year	1 per calendar year	1 per calendar year	None
Pediatric Dental			
Carrier	Anthem Dental	Anthem Dental	Dental Benefit Providers [22, 24]
Network	Prime	Prime	Dental Benefit Providers
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	80%	80%	Copay varies by service
Major Services (no waiting period)	50%	50%	Copay varies by service
Orthodontics (medically necessary)	50%	50%	Copay varies by service

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. See plan specific EOC for information on preventive services.
2. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
3. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
4. Limited to 100 4-hour visits per benefit period.
5. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
6. Evaluation only.
7. Maximum member responsibility.
8. Medical emergency only.
9. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
10. In an office setting.
11. Manipulation Therapy only: benefit maximum of 30 visits per benefit period for office visits.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.
17. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
18. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
19. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
20. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

(Footnotes continued on page 85)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,300 / $4,600 [3] (applies to Max OOP)	$1,900 / $3,800 [3] (combined Med/Rx ded) (applies to Max OOP)	$2,500 / $5,000 [3] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,750 / $17,500 [8]	$8,750 / $17,500 [8]	$8,750 / $17,500 [8]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay (ded waived)	$65 Copay (ded waived)	$55 Copay (ded waived)
Specialist Visit (SPC)	$100 Copay (ded waived)	$100 Copay (ded waived)	$90 Copay (ded waived)
Laboratory	$30 Copay (ded waived)	$30 Copay (ded waived)	$55 Copay (ded waived)
X-Ray	$75 Copay (ded waived)	$75 Copay (ded waived)	$90 Copay (ded waived)
MRI, CT and PET (office setting)	$400 Copay per procedure	$400 Copay per procedure	$300 Copay per procedure
Virtual/Telemedicine Office Visit	100% (ded waived)	100% (ded waived)	100% (ded waived)
Hospital Services – In-Patient	55%	55%	65%
In-Patient Physician Fees	55%	55%	65%
Emergency Room (copay waived if admitted)	55%	55%	65%
Urgent Care	$65 Copay (ded waived)	$65 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 55% 55%	 55% 55%	 65% 65%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$100 Copay (ded waived)	$100 Copay (ded waived)	$90 Copay (ded waived)
Ambulance Services (per trip)	55%	55%	65%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $500 / $1,000 Ded - $100 Copay $500 / $1,000 Ded - $100 Copay (with physician approval) $500 / $1,000 Ded – 80% (up to $250 per prescription [9]) (with physician approval)	 $20 Copay (ded waived) $100 Copay (ded waived) $100 Copay (ded waived) (with physician approval) 80% (up to $250 per prescription [9]) (combined Med/Rx ded) (with physician approval)	 $19 Copay (ded waived) $300 / $600 Ded - $85 Copay $300 / $600 Ded - $85 Copay (with physician approval) $300 / $600 Ded – 70% (up to $250 per prescription [9]) (with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded - $100 Copay	$100 Copay (ded waived)	$300 / $600 Ded - $85 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	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100% (ded waived)	100% (ded waived)	65% (ded waived)
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [2]	$15 Copay (ded waived) [2]	Not Covered
Acupuncture	$65 Copay (ded waived) [2]	$65 Copay (ded waived) [2]	$55 Copay (ded waived)
Physical, Occupational, Speech Therapy	$65 Copay (ded waived)	$65 Copay (ded waived)	$55 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived)	$65 Copay (ded waived)	$55 Copay (ded waived)
Home Health Care (Max 100 visits per year)	100% (ded waived) [10]	100% (ded waived) [10]	$45 Copay (ded waived) [10]

Silver HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO B	HMO C
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	55%	55%	65%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	55% [6, 11]	55% [6, 11]	65% [6, 11]
Mental Health			
In-Patient	55%	55%	65%
Out-Patient (office visit)	100% (ded waived)	100% Copay (ded waived)	100% (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	55%	55%	65%
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	Kaiser Permanente
Network	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Exam	100% (ded waived)	100% (ded waived)	100% (ded waived)
Contact Lenses	1 pair per calendar year [7]	1 pair per calendar year [7]	1 pair per calendar year [7]
Frames	1 pair per calendar year (ded waived) [7]	1 pair per calendar year (ded waived) [7]	1 pair per calendar year (ded waived) [7]
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700	$350 / $700
Office Visit	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	$95 Copay [4]	$95 Copay [4]	$95 Copay [4]
Major Services (no waiting period)	$365 Copay [5]	$365 Copay [5]	$365 Copay [5]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. See plan specific EOC for information on preventive services.
2. 20 visits max per year combined for Chiropractic and Acupuncture.
3. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
4. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
5. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
8. Under a family contract, an insured can satisfy their individual out-of-pocket maximum however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
9. Maximum member responsibility.
10. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
11. Supplemental Durable Medical Equipment has a $2,000 annual maximum.

Silver HMO

Groups Beginning 4.1.2025

Services	HMO D† HSA Qualified	HMO E	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,850 / $3,300 / $5,700 [11, 20] (combined Med/Rx ded) (applies to Max OOP)	$2,900 / $5,800 [11] (combined Med/Rx ded) (applies to Max OOP)	$2,600 / $5,200 [7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000 [12]	$9,100 / $18,200 [12]	$9,200 / $18,400 [2, 7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	75%	$65 Copay (ded waived)	$45 Copay (ded waived)
Specialist Visit (SPC)	75%	$100 Copay (ded waived)	$60 Copay (ded waived)
Laboratory	75%	$30 Copay	$15 Copay
X-Ray	75%	$75 Copay	$55 Copay
MRI, CT and PET (office setting)	75% per procedure	$400 Copay per procedure	$300 Copay
Virtual/Telemedicine Office Visit	100%	100% (ded waived)	Covered as any Illness
Hospital Services – In-Patient	75%	55%	$975 Copay per day
In-Patient Physician Fees	75%	55%	100%
Emergency Room (copay waived if admitted)	75%	55%	$750 Copay
Urgent Care	75%	$65 Copay (ded waived)	$60 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	75%	55% 55%	50% 50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	75%	$100 Copay (ded waived)	$60 Copay (ded waived)
Ambulance Services (per trip)	75%	55%	$400 Copay (ded waived)
Rx Benefits Generic	75% (Up to $250 per prescription [13]) (combined Med/Rx ded)	$20 Copay (ded waived)	$16 Copay (ded waived)
Formulary Brand	75% (Up to $250 per prescription [13]) (combined Med/Rx ded)	$100 Copay (combined Med/Rx ded)	$300 / $600 Ded – $120 Copay
Non-Formulary Brand	75% (Up to $250 per prescription [13]) (combined Med/Rx ded) (with physician approval)	$100 Copay (combined Med/Rx ded) (with physician approval)	$300 / $600 Ded – $135 Copay
Specialty	75% (up to $250 per prescription [13]) (combined Med/Rx ded) (with physician approval)	55% (up to $250 per prescription [13]) (combined Med/Rx ded) (with physician approval)	$300 / $600 Ded – Applicable Rx Copay
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (if in formulary)
Diabetes – Self-Injectable	75% (Up to $250 per prescription [13]) (combined Med/Rx ded)	$100 Copay (combined Med/Rx ded)	$300 / $600 Ded – Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	$720 Copay per day [8]
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	$60 Copay (ded waived)
Chemotherapy	75%	100% (ded waived)	Variable [3]
Chiropractic (20 visits max per year)	Not Covered	$15 Copay (ded waived) [14]	Not Covered
Acupuncture	75%	$65 Copay (ded waived) [14]	$45 Copay (ded waived)
Physical, Occupational, Speech Therapy	75%	$65 Copay (ded waived)	$45 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	75%	$65 Copay (ded waived)	$45 Copay (ded waived)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO D† HSA Qualified	HMO E	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	75% [15]	100% (ded waived) [15]	$45 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	75%	55%	$25 Copay per day
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	75% [16, 21]	55% [16, 21]	50%
Mental Health In-Patient Out-Patient (office visit)	 75% 100%	 55% 100% (ded waived)	 $90 Copay per day $45 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 75%	 55%	 $90 Copay per day
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 [17] 1 pair per calendar year (ded waived) [17] None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [17] 1 pair per calendar year (ded waived) [17] None	 VSP VSP Advantage Network 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 [18] $365 Copay [19] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [18] $365 Copay [19] $350 Copay	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [4] 100% [9] $25 Copay [5] $300 Copay [6] $1,000 Copay [10]

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. See plan specific EOC for information on preventive services.
2. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
3. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
4. Refers to procedure code D0999
5. Refers to procedure code D2140
6. Refers to procedure code D3330
7. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.
8. Amount listed for In-Patient Services only.
9. Refers to procedure codes D0120 and D1120/D1110
10. Refers to procedure code D8080/D8090
11. 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.
12. 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.
13. Maximum member responsibility.
14. 20 visits max per year combined for Chiropractic and Acupuncture.
15. 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).
16. 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.
17. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
18. 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.
19. 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.
20. $2,850 Self only enrollment, $3,300 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.
21. Supplemental Durable Medical Equipment has a $2,000 annual maximum.

Silver HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C	HMO B
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sutter Health Plan
Network Name	Performance	Premier	Sutter Health Plan
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,600 / $5,200 [18] (applies to Max OOP)	$2,900 / $5,800 [18] (applies to Max OOP)	$2,500 / $5,000 [7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$9,200 / $18,400 [2, 18]	$9,200 / $18,400 [2, 18]	$8,750 / $17,500 [9]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived) [8]
Specialist Visit (SPC)	$60 Copay (ded waived)	$65 Copay (ded waived)	$90 Copay (ded waived)
Laboratory	$15 Copay	$15 Copay	$55 Copay (ded waived)
X-Ray	$60 Copay	$55 Copay	$90 Copay per procedure (ded waived)
MRI, CT and PET (office setting)	$225 Copay	$300 Copay	$300 Copay per procedure
Virtual/Telemedicine Office Visit	Covered as any Illness	Covered as any Illness	Variable [16]
Hospital Services – In-Patient	60%	50%	65%
In-Patient Physician Fees	60%	50%	65% (ded waived)
Emergency Room (copay waived if admitted)	60%	50%	65%
Urgent Care	$60 Copay (ded waived)	$65 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 50% 50%	 65% 65%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay (ded waived)	$65 Copay (ded waived)	$90 Copay (ded waived)
Ambulance Services (per trip)	60% (ded waived)	50% (ded waived)	65%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $16 Copay (ded waived) $300 / $600 Ded – $110 Copay $300 / $600 Ded – $160 Copay $300 / $600 Ded – Applicable Rx Copay	 $16 Copay (overall ded waived) $145 Copay (overall ded waived) $150 Copay (overall ded waived) Applicable Rx Copay (overall ded waived)	 $19 Copay (ded waived) [11] $300 / $600 Ded – $85 Copay [11] $300 / $600 Ded – $110 Copay [11] $300 / $600 Ded – 70% (up to $250 per prescription [3]) [11]
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100% (ded waived)
Diabetes – Self-Injectable	$300 / $600 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)	$300 / $600 Ded – Applicable Rx Copay [11]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	60% [19]	50% [19]	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	$60 Copay (ded waived)	$65 Copay (ded waived)	Covered as any Illness
Chemotherapy	Variable [17]	Variable [17]	65% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$40 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Physical, Occupational, Speech Therapy	$40 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$40 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C	HMO B
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sutter Health Plan
Network Name	Performance	Premier	Sutter Health Plan
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	$40 Copay (ded waived)	$55 Copay (ded waived)	$45 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	50%	65%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	65% (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 60% $40 Copay (ded waived)	 50% $55 Copay (ded waived)	 65% [13] $55 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 50%	 65% [13]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [14] 100% (in lieu of eyeglasses) (ded waived) [14, 15] 100% (in lieu of contact lenses) (ded waived) [14, 15] 1 pair per year
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 of California Delta Dental DeltaCare USA None Combined with Medical 100% [4] 100% [20] $25 Copay [5] $300 Copay [6] $1,000 Copay [12]	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [4] 100% [20] $25 Copay [5] $300 Copay [6] $1,000 Copay [12]	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

1. See plan specific EOC for information on preventive services.
2. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
3. Maximum member responsibility.
4. Refers to procedure code D0999
5. Refers to procedure code D2140
6. Refers to procedure code D3330
7. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plan pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plan pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plan pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,300 for 2025 plans.
8. Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk-in Care visits.
9. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
10. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
11. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be up to four times the retail cost share. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

(Footnotes continued on page 85)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO C† HSA Qualified	HMO A	HMO E
Participating Health Plans	Sutter Health Plan	UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plan	SignatureValue	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,800 / $3,300 / $5,600 [10,12] (combined Med/Rx ded) (applies to Max OOP)	$2,400 / $4,800 [5] (applies to Max OOP)	$2,400 / $4,800 [5] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,200 / $14,400 [9]	$9,200 / $18,400 [6]	$9,200 / $18,400 [6]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay [8]	$60 Copay (ded waived)	$60 Copay (ded waived)
Specialist Visit (SPC)	$50 Copay	$95 Copay (ded waived)	$95 Copay (ded waived)
Laboratory	$35 Copay	$45 Copay (ded waived)	$45 Copay (ded waived)
X-Ray	$15 Copay per procedure	$45 Copay (ded waived)	$45 Copay (ded waived)
MRI, CT and PET (office setting)	$50 Copay per procedure	$400 Copay per procedure (ded waived)	$400 Copay per procedure (ded waived)
Virtual/Telemedicine Office Visit	Variable [16]	100% (ded waived)	100% (ded waived)
Hospital Services – In-Patient	75%	60%	60%
In-Patient Physician Fees	75%	60% (ded waived)	60% (ded waived)
Emergency Room (copay waived if admitted)	75%	60%	60%
Urgent Care	$35 Copay	$125 Copay (ded waived)	$125 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 75% 75%	 60% 60%	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$95 Copay (ded waived)	$95 Copay (ded waived)
Ambulance Services (per trip)	75%	$100 Copay (ded waived)	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (combined Med/Rx ded) [11] $40 Copay (combined Med/Rx ded) [11] $60 Copay (combined Med/Rx ded) [11] 75% (up to $250 per prescription [3]) (combined Med/Rx ded) [11]	 Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [7] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [7] $400 / $800 Ded – Tier 3 Non-specialty $125 Copay / Tier 3 Specialty $250 Copay [7] $400 / $800 Ded – Tier 4 75% (up to $250 per prescription [3]) [4]	 Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [7] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [7] $400 / $800 Ded – Tier 3 Non-specialty $125 Copay / Tier 3 Specialty $250 Copay [7] $400 / $800 Ded – Tier 4 75% (up to $250 per prescription [3]) [4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (combined Med/Rx ded) [11]	Applicable Ded / Rx Copay	Applicable Ded / Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [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	75%	$150 Copay (ded waived) [2]	$150 Copay (ded waived) [2]
Chiropractic (20 visits max per year)	Not Covered	$15 Copay (ded waived)	$15 Copay (ded waived)
Acupuncture	$35 Copay	$10 Copay (ded waived)	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$35 Copay	$60 Copay (ded waived)	$60 Copay (ded waived)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO C† HSA Qualified	HMO A	HMO E
Participating Health Plans	Sutter Health Plan	UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plan	SignatureValue	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Rehabilitative & Habilitative Services and Devices	$35 Copay	$60 Copay (ded waived)	$60 Copay (ded waived)
Home Health Care (Max 100 visits per year)	75%	$60 Copay (ded waived)	$60 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	75%	60%	60%
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	75%	$70 Copay (ded waived)	$70 Copay (ded waived)
Mental Health			
In-Patient	75% [13]	60%	60%
Out-Patient (office visit)	$35 Copay	$60 Copay (ded waived)	$60 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	75% [13]	60%	60%
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	Choice Network	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100% (ded waived) [14]	100% (ded waived)	100% (ded waived)
Contact Lenses	100% (in lieu of eyeglasses) (ded waived) [14, 15]	60% (ded waived)	60% (ded waived)
Frames	100% (in lieu of contact lenses) (ded waived) [14, 15]	60% (ded waived)	60% (ded waived)
Maximum Allowance per year	1 pair per year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	Delta Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	DeltaCare USA	CA DHMO	CA DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service (ded waived)	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	Copay varies by service (ded waived)	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service (ded waived)	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay (ded waived)	$350 Copay	$350 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† 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. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
3. Maximum member responsibility.
4. No change to how Specialty Drugs in Tier 4 are filled today.
5. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
6. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
7. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.
8. Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk-in Care visits.
9. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
10. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
11. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be up to four times the retail cost share. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

(Footnotes continued on page 86)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO F	HMO G	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Harmony	Harmony	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,400 / $4,800 [15] (applies to Max OOP)	$2,000 / $4,000 [15] (applies to Max OOP)	$2,300 / $4,600 [1, 10] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$9,200 / $18,400 [16]	$9,200 / $18,400 [16]	$8,750 / $17,500 [2, 10]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	60%	$50 Copay (ded waived)
Specialist Visit (SPC)	$95 Copay (ded waived)	60%	$50 Copay (ded waived)
Laboratory	$45 Copay (ded waived)	60%	$50 Copay (ded waived)
X-Ray	$45 Copay (ded waived)	60%	$75 Copay (ded waived)
MRI, CT and PET (office setting)	$400 Copay per procedure (ded waived)	60%	$350 Copay (ded waived)
Virtual/Telemedicine Office Visit	100% (ded waived)	100% (ded waived)	Variable [13]
Hospital Services – In-Patient	60%	60%	70% [1, 4]
In-Patient Physician Fees	60% (ded waived)	60%	100% (ded waived)
Emergency Room (copay waived if admitted)	60%	60%	70% [1, 4]
Urgent Care	$125 Copay (ded waived)	60%	$100 Copay [1]
Hospital Services – Out-Patient			
Surgical Facility	60%	60%	$350 Copay [1]
Ambulatory Surgery Center	60%	60%	$350 Copay [1]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$95 Copay (ded waived)	60%	$50 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	60%	100% (ded waived)
Rx Benefits			
Generic	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [17]	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [17]	$20 Copay (ded waived)
Formulary Brand	$400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [17]	$400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [17]	$500 / $1,000 Ded - 70% (up to $250 per 30 day supply [8]) [1, 4, 11]
Non-Formulary Brand	$400 / $800 Ded – Tier 3 Non-specialty $125 Copay / Tier 3 Specialty $250 Copay [17]	$400 / $800 Ded – Tier 3 Non-specialty $125 Copay / Tier 3 Specialty $250 Copay [17]	$500 / $1,000 Ded - 70% (up to $250 per 30 day supply [8]) [1, 4, 11]
Specialty	$400 / $800 Ded – Tier 4 75% (up to $250 per prescription [8]) [14]	$400 / $800 Ded – Tier 4 75% (up to $250 per prescription [8]) [14]	$500 / $1,000 Ded - 70% (up to $250 per 30 day supply [8]) [1, 4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay	Applicable Ded / Rx Copay	$500 / $1,000 Ded - 70% (up to $250 per 30 day supply [8]) [1, 4]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [6]	100% (ded waived) [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) [9]	$150 Copay (ded waived) [9]	100% (ded waived)
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay	$15 Copay (ded waived) [12]
Acupuncture	$10 Copay (ded waived)	60%	$15 Copay (ded waived)
Physical, Occupational, Speech Therapy	$60 Copay (ded waived)	60%	$50 Copay (ded waived)

Silver HMO

Groups Beginning 4.1.2025

Services	HMO F	HMO G	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Harmony	Harmony	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived)	60%	$50 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$60 Copay (ded waived)	60%	100% (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	70% [1, 4]
Hospice (out-patient)	100% (ded waived)	60%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$70 Copay (ded waived)	$70 Copay (ded waived)	80% (ded waived) [4, 5]
Mental Health			
In-Patient	60%	60%	70% [1, 4]
Out-Patient (office visit)	$60 Copay (ded waived)	60%	$50 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	60%	70% [1, 4]
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	UnitedHealthcare Vision	UnitedHealthcare Vision	EyeMed
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	Eyewear Only
Exam	100% (ded waived)	100% (ded waived)	100% (ded waived)
Contact Lenses	60% (ded waived)	60% (ded waived)	100% (ded waived)
Frames	60% (ded waived)	60% (ded waived)	100% (ded waived)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year [7]
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	Delta Dental
Network	CA DHMO	CA DHMO	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100% (ded waived)	100% (ded waived)	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	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)	$350 Copay	$350 Copay	$1,000 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* 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 or medication.
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 and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable contact lenses instead of glasses.
8. Maximum member responsibility.
9. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
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. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or contribute to the out-of-pocket maximum.
12. Copayments do not contribute to out-of-pocket maximum.
13. Cost share amount varies based on type of services rendered.
14. No change to how Specialty Drugs in Tier 4 are filled today.
15. 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.
16. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
17. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.

Silver HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,500 / $5,000 [1, 10] (applies to Max OOP)	$2,850 / $3,300 / $5,700 [1, 9, 10] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,750 / $17,500 [2, 10]	$7,500 / $15,000 [2, 10]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$55 Copay (ded waived)	75% [1, 4]
Specialist Visit (SPC)	$90 Copay (ded waived)	75% [1, 4]
Laboratory	$55 Copay (ded waived)	75% [1, 4]
X-Ray	$90 Copay (ded waived)	75% [1, 4]
MRI, CT and PET (office setting)	$300 Copay [1]	75% [1, 4]
Virtual/Telemedicine Office Visit	Variable [13]	Variable [13]
Hospital Services – In-Patient	65% [1, 4]	75% [1, 4]
In-Patient Physician Fees	65% (ded waived) [4]	75% [1, 4]
Emergency Room (copay waived if admitted)	65% [1, 4]	75% [1, 4]
Urgent Care	$55 Copay (ded waived)	75% [1, 4]
Hospital Services – Out-Patient		
Surgical Facility	65% [1, 4]	75% [1, 4]
Ambulatory Surgery Center	65% [1, 4]	75% [1, 4]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$90 Copay (ded waived)	75% [1, 4]
Ambulance Services (per trip)	65% [1, 4]	75% [1, 4]
Rx Benefits		
Generic	$19 Copay (ded waived)	75% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
Formulary Brand	$300 / $600 Ded – $85 Copay [1, 11]	75% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4, 11]
Non-Formulary Brand	$300 / $600 Ded – $110 Copay [1, 11]	75% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4, 11]
Specialty	$300 / $600 Ded – 70% (up to $250 per 30 day supply [8]) [1, 4]	75% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$300 / $600 Ded – $85 Copay [1]	75% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
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	65% [1, 4]	75% [1, 4]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$15 Copay (ded waived)	100% [1]
Physical, Occupational, Speech Therapy	$55 Copay (ded waived)	75% [1, 4]

Silver HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Silver**	**Silver**
Rehabilitative & Habilitative Services and Devices	$55 Copay (ded waived)	75% [1, 4]
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	75% [1, 4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [1, 4]	75% [1, 4]
Hospice (out-patient)	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	65% (ded waived) [4, 5]	75% [1, 4, 5]
Mental Health		
In-Patient	65% [1, 4]	75% [1, 4]
Out-Patient (office visit)	$55 Copay (ded waived)	75% [1, 4]
Drug/Substance Abuse		
In-Patient (Detox Only)	65% [1, 4]	75% [1, 4]
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	EyeMed	EyeMed
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 [7]	1 per calendar year [7]
Pediatric Dental		
Carrier	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA
Deductible	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical
Office Visit	100%	100%
Diagnostic & Preventative (D&P)	100%	100%
Basic Services	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† 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 or medication.
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 and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable 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. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or contribute to the out-of-pocket maximum.
12. Copayments do not contribute to out-of-pocket maximum.
13. Cost share amount varies based on type of services rendered.

Silver PPO

Groups Beginning 4.1.2025

Services	PPO B		PPO C	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Prudent Buyer – Small Group	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$1,700 / $3,400 (applies to Max OOP)	$3,400 / $6,800 (applies to Max OOP)	$1,700 / $3,400 (applies to Max OOP)	$3,400 / $6,800 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$9,100 / $18,200 [1]	$18,200 / $36,400 [1]	$9,100 / $18,200 [1]	$18,200 / $36,400 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$50 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Specialist Visit (SPC)	$95 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
Laboratory	$20 Copay (ded waived)	50%	$20 Copay (ded waived)	50%
X-Ray	$20 Copay (ded waived)	50%	$20 Copay (ded waived)	50%
MRI, CT and PET (office setting)	60%	50% (up to $800 per test) [5]	60%	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	$50 Copay / $95 Copay (ded waived) [15]	50%	$50 Copay / $95 Copay (ded waived) [15]	50%
Hospital Services – In-Patient	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
In-Patient Physician Fees	60%	50%	60%	50%
Emergency Room (copay waived if admitted)	$300 Copay – 60%		$300 Copay – 60%	
Urgent Care	$50 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit – 60% $50 Copay per admit – 60%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit – 60% $50 Copay per admit – 60%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$95 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
Ambulance Services (per trip)	60% [13]		60% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [2] $300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [2] $300 / $600 Ded - Level 1 $110 Copay / Level 2 $120 Copay [2] $300 / $600 Ded – Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [2] $300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [2] $300 / $600 Ded - Level 1 $110 Copay / Level 2 $120 Copay [2] $300 / $600 Ded – Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
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 [16]		Covered [16]	
Chemotherapy	60%	50% [14]	60%	50% [14]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$50 Copay (ded waived)	Not Covered	$50 Copay (ded waived)	Not Covered

Silver PPO

Groups Beginning 4.1.2025

Services	PPO B		PPO C	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Prudent Buyer - Small Group	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	50% [14]	$50 Copay (ded waived)	50% [14]
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [11]	50% [11]	$50 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	60% (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)	60% [12]	50% (up to $150 per day) [5, 12]	60% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health				
In-Patient	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
Out-Patient (office visit)	$50 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	$50 Copay (ded waived) [7]	50% [7]	$50 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	None	None	None	None
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%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

(Footnotes continued on page 86)

Silver PPO

Groups Beginning 4.1.2025

Services	PPO D† HSA Qualified		PPO E† HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$2,000 / $3,300 / $4,000 (combined Med/Rx ded) (applies to Max OOP)	$4,000 / $6,600 / $8,000 (combined Med/Rx ded) (applies to Max OOP)	$2,000 / $3,300 / $4,000 (combined Med/Rx ded) (applies to Max OOP)	$4,000 / $6,600 / $8,000 (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,700 / $15,400 [1]	$15,400 / $30,800 [1]	$7,700 / $15,400 [1]	$15,400 / $30,800 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	65%	50%	65%	50%
Specialist Visit (SPC)	65%	50%	65%	50%
Laboratory	65%	50%	65%	50%
X-Ray	65%	50%	65%	50%
MRI, CT and PET (office setting)	65% [14]	50% (up to $800 per test) [5]	65% [14]	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	65% / 65% [15]	50%	65% / 65% [15]	50%
Hospital Services –In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%		65%	
Urgent Care	65%	50%	65%	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit – 65% $50 Copay per admit – 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit – 65% $50 Copay per admit – 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	65%	50%	65%	50%
Ambulance Services (per trip)	65% [13]		65% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $15 Copay / Level 2 $20 Copay (combined Med/Rx ded) [2, 17] Level 1 $70 Copay / Level 2 $80 Copay (combined Med/Rx ded) [2, 17] Level 1 $110 Copay / Level 2 $120 Copay (combined Med/Rx ded) [2] Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (combined Med/Rx ded) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 Level 1 $15 Copay / Level 2 $20 Copay (combined Med/Rx ded) [2, 17] Level 1 $70 Copay / Level 2 $80 Copay (combined Med/Rx ded) [2, 17] Level 1 $110 Copay / Level 2 $120 Copay (combined Med/Rx ded) [2] Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (combined Med/Rx ded) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2, 17]	Not Covered	Applicable Ded / Rx Copay [2, 17]	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 [16]		Covered [16]	
Chemotherapy	65%	50% [14]	65%	50% [14]
Chiropractic (20 visits max per year)	50% (20 visits max per benefit period) [10]	Not Covered	50% (20 visits max per benefit period) [10]	Not Covered
Acupuncture	65%	Not Covered	65%	Not Covered

Silver PPO

Groups Beginning 4.1.2025

Services	PPO D† HSA Qualified		PPO E† HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Physical, Occupational, Speech Therapy	65%	50% [14]	65%	50% [14]
Rehabilitative & Habilitative Services and Devices	65% [11]	50% [11]	65% [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [12]	50% (up to $150 per day) [5, 12]	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health				
In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
Out-Patient (office visit)	65%	50%	65%	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	65% [7]	50% [7]	65% [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 (ded waived)	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
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	None	None	None	None
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%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

(Footnotes continued on page 86)

Bronze HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,800 / $11,600 [17] (applies to Max OOP)	$6,650 / $13,300 [17] (combined Med/Rx ded) (applies to Max OOP)	$7,600 / $15,200 [1] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,850 / $17,700 [2]	$6,650 / $13,300 [2]	$8,500 / $17,000 [1, 11]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	100%	$55 Copay
Specialist Visit (SPC)	$95 Copay [20]	100%	$55 Copay
Laboratory	$40 Copay (ded waived)	100%	$15 Copay
X-Ray	60%	100%	$55 Copay
MRI, CT and PET (office setting)	60% per procedure	100% per procedure	$175 Copay
Virtual/Telemedicine Office Visit	100% (ded waived)	100%	Covered as any Illness
Hospital Services – In-Patient	60%	100%	$1,500 Copay per day – 3 days max
In-Patient Physician Fees	60%	100%	100%
Emergency Room (copay waived if admitted)	60%	100%	$500 Copay
Urgent Care	$60 Copay (ded waived)	100%	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 100% 100%	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$95 Copay [20]	100%	$55 Copay
Ambulance Services (per trip)	60%	100%	$500 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $19 Copay (ded waived) $450 / $900 Ded – 60% (up to $500 per prescription [6]) $450 / $900 Ded – 60% (up to $500 per prescription [6]) (with physician approval) $450 / $900 Ded – 60% (up to $500 per prescription [6]) (with physician approval)	 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) (with physician approval) 100% (combined Med/Rx ded) (with physician approval)	 $16 Copay (overall ded waived) $60 Copay (overall ded waived) $100 Copay (overall ded waived) Applicable Rx Copay (overall ded waived)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (if in formulary)
Diabetes – Self-Injectable	$450 / $900 Ded – 60% (up to $500 per prescription [6])	100% (combined Med/Rx ded)	Applicable Rx Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	$800 Copay per day – 3 days max [9]
Preventive/Wellness Services	100% (ded waived) [4]	100% (ded waived) [4]	100% (ded waived) [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	$55 Copay
Chemotherapy	60%	100%	Variable [5]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$60 Copay (ded waived)	100%	$55 Copay
Physical, Occupational, Speech Therapy	$60 Copay (ded waived)	100%	$55 Copay
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived)	100%	$55 Copay

Bronze HMO

Groups Beginning 4.1.2025

Services	HMO A	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60% [10]	100% [10]	$55 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100%	$25 Copay per day
Hospice (out-patient)	100% (ded waived)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60% [19, 21]	100% [19, 21]	50%
Mental Health			
In-Patient	60%	100%	$125 Copay per day – 3 days max
Out-Patient (office visit)	100% (ded waived)	100%	$55 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	100%	$125 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 Advantage Network
Exam	100% (ded waived)	100% (ded waived)	100%
Contact Lenses	1 pair per calendar year [12]	1 pair per calendar year [12]	1 pair in lieu of eyeglasses
Frames	1 pair per calendar year (ded waived) [12]	1 pair per calendar year (ded waived) [12]	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental of California
Network	DeltaCare USA	DeltaCare USA	Delta Dental DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700	Combined with Medical
Office Visit	100% (ded waived)	100% (ded waived)	100% [3]
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% [14]
Basic Services	$95 Copay [7]	$95 Copay [7]	$25 Copay [15]
Major Services (no waiting period)	$365 Copay [8]	$365 Copay [8]	$300 Copay [16]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$1,000 Copay [13]

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

† HSA Qualified High Deductible Plan

1. 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.
2. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
3. Refers to procedure code D0999
4. See plan specific EOC for information on preventive services.
5. Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
6. Maximum member responsibility.
7. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
8. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
9. Amount listed for In-Patient Services only.
10. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
11. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
12. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
13. Refers to procedure code D8080/D8090
14. Refers to procedure codes D0120 and D1120/D1110
15. Refers to procedure code D2140
16. Refers to procedure code D3330
17. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
18. 20 visits max per year combined for Chiropractic and Acupuncture.
19. 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.
20. Deductible is waived for first three visits.
21. Supplemental Durable Medical Equipment has a $2,000 annual maximum.

Bronze HMO

Groups Beginning 4.1.2025

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sharp Health Plan	Sutter Health Plan	Sutter Health Plan
Network Name	Performance	Sutter Health Plan	Sutter Health Plan
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,200 / $12,400 [10] (combined Med/Rx ded) (applies to Max OOP)	$5,800 / $11,600 [1] (applies to Max OOP)	$6,650 / $13,300 [1] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,100 / $14,200 [10, 17]	$8,850 / $17,700 [2]	$6,650 / $13,300 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$60 Copay (ded waived) [9]	100% [9]
Specialist Visit (SPC)	60%	$95 Copay [8]	100%
Laboratory	60%	$40 Copay (ded waived)	100%
X-Ray	60%	60%	100%
MRI, CT and PET (office setting)	60%	60%	100%
Virtual/Telemedicine Office Visit	Covered as any Illness	Variable [4]	Variable [4]
Hospital Services – In-Patient	60%	60%	100%
In-Patient Physician Fees	60%	60%	100%
Emergency Room (copay waived if admitted)	60%	60%	100%
Urgent Care	60%	$60 Copay (ded waived)	100%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	$95 Copay [8]	100%
Ambulance Services (per trip)	60%	60%	100%
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) Applicable Rx Copay (combined Med/Rx ded)	 $19 Copay (ded waived) [3] $450 / $900 Ded – 60% (up to $500 per prescription [15]) [3] $450 / $900 Ded – 60% (up to $500 per prescription [15]) [3] $450 / $900 Ded – 60% (up to $500 per prescription [15]) [3]	 100% (combined Med/Rx ded) [3] 100% (combined Med/Rx ded) [3] 100% (combined Med/Rx ded) [3] 100% (combined Med/Rx ded) [3]
Oral Contraceptives	100% (if in formulary)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (combined Med/Rx ded)	$450 / $900 Ded – Applicable Rx Copay [3]	Applicable Rx Copay (combined Med/Rx ded) [3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	60% [18]	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%	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [11]	60%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	60%	$60 Copay (ded waived)	100%
Physical, Occupational, Speech Therapy	60%	$60 Copay (ded waived)	100%
Rehabilitative & Habilitative Services and Devices	60%	$60 Copay (ded waived)	100%

Bronze HMO

Groups Beginning 4.1.2025

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sharp Health Plan	Sutter Health Plan	Sutter Health Plan
Network Name	Performance	Sutter Health Plan	Sutter Health Plan
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	60%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	100%
Hospice (out-patient)	100%	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	50%	60%	100%
Mental Health			
In-Patient	60%	60% [16]	100% [16]
Out-Patient (office visit)	60%	$60 Copay (ded waived)	100%
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	60% [16]	100% [16]
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 Advantage Network	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% (in lieu of contact lenses) (ded waived) [6, 7]	100% (in lieu of contact lenses) (ded waived) [6, 7]
Maximum Allowance per year	None	1 pair per year	1 pair per year
Pediatric Dental			
Carrier	Delta Dental of California	Delta Dental	Delta Dental
Network	Delta Dental DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100% [14]	Copay varies by service (ded waived)	Copay varies by service
Diagnostic & Preventative (D&P)	100% [18]	100% (ded waived)	100% (ded waived)
Basic Services	$25 Copay [12]	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Major Services (no waiting period)	$300 Copay [13]	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Orthodontics (medically necessary)	$1,000 Copay [19]	$1,000 Copay (ded waived)	$1,000 Copay (ded waived)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† HSA Qualified High Deductible Plan

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

1. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plan pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plan pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plan pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,300 for 2025 plans.
2. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
3. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be up to four times the retail cost share. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
4. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every calendar year.
8. When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non-preventive visits", the deductible is waived for the first three non-preventive visits combined.

(Footnotes continued on page 87)

Bronze HMO

Groups Beginning 4.1.2025

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*	$5,800 / $11,600 [1, 7] (applies to Max OOP)	$6,650 / $13,300 [1, 7] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,850 / $17,700 [2, 7]	$6,650 / $13,300 [2, 7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	100% [1]
Specialist Visit (SPC)	$95 Copay [9]	100% [1]
Laboratory	$40 Copay (ded waived)	100% [1]
X-Ray	60% [1, 4]	100% [1]
MRI, CT and PET (office setting)	60% [1, 4]	100% [1]
Virtual/Telemedicine Office Visit	Variable [13]	Variable [13]
Hospital Services – In-Patient	60% [1, 4]	100% [1]
In-Patient Physician Fees	60% [1, 4]	100% [1]
Emergency Room (copay waived if admitted)	60% [1, 4]	100% [1]
Urgent Care	$60 Copay (ded waived)	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$95 Copay [9]	100% [1]
Ambulance Services (per trip)	60% [1, 4]	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $19 Copay (ded waived) $450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4, 11] $450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4, 11] $450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4]	 100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4]	100% (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	60% [1, 4]	100% [1]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$15 Copay (ded waived)	100% [1]
Physical, Occupational, Speech Therapy	$60 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived)	100% [1]

Bronze HMO

Groups Beginning 4.1.2025

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60% [1, 4]	100% [1]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% [1, 4]	100% [1]
Hospice (out-patient)	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	60% [1, 4, 5]	100% [1]
Mental Health		
In-Patient	60% [1, 4]	100% [1]
Out-Patient (office visit)	$60 Copay (ded waived)	100% [1]
Drug/Substance Abuse		
In-Patient (Detox Only)	60% [1, 11]	100% [1]
Infertility		
Infertility Evaluation and Treatment	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	EyeMed	EyeMed
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

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† 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 or medication.
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. The deductible is waived for first three combined visits for non-preventive specialty care visits.
10. Limited to one pair of glasses with standard lenses and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable contact lenses instead of glasses.
11. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or contribute to the out-of-pocket maximum.
12. Copayments do not contribute to out-of-pocket maximum.
13. Cost share amount varies based on type of services rendered.

Bronze PPO

Groups Beginning 4.1.2025

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$6,250 / $12,500 (combined Med/Rx ded) (applies to Max OOP)	$12,500 / $25,000 (combined Med/Rx ded) (applies to Max OOP)	$6,250 / $12,500 (combined Med/Rx ded) (applies to Max OOP)	$12,500 / $25,000 (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [1]	$14,700 / $29,400 [1]	$7,350 / $14,700 [1]	$14,700 / $29,400 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	65%	50%	65%	50%
Specialist Visit (SPC)	65%	50%	65%	50%
Laboratory	65%	50%	65%	50%
X-Ray	65%	50%	65%	50%
MRI, CT and PET (office setting)	65%	50% (up to $800 per test) [5]	65%	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	65% / 65% [15]	50%	65% / 65% [15]	50%
Hospital Services –In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%		65%	
Urgent Care	65%	50%	65%	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit - 65% $50 Copay per admit - 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit - 65% $50 Copay per admit - 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	65%	50%	65%	50%
Ambulance Services (per trip)	65% [13]		65% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $20 Copay / Level 2 $20 Copay (combined Med/Rx ded) [2, 17] Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx ded) [2, 17] Level 1 $160 Copay / Level 2 $170 Copay (combined Med/Rx ded) [2] Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (combined Med/Rx ded) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 Level 1 $20 Copay / Level 2 $20 Copay (combined Med/Rx ded) [2, 17] Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx ded) [2, 17] Level 1 $160 Copay / Level 2 $170 Copay (combined Med/Rx ded) [2] Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (combined Med/Rx ded) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2, 17]	Not Covered	Applicable Ded / Rx Copay [2, 17]	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 [16]		Covered [16]	
Chemotherapy	65%	50% [14]	65%	50% [14]
Chiropractic (20 visits max per year)	50% (20 visits max per benefit period) [10]	Not Covered	50% (20 visits max per benefit period) [10]	Not Covered

Bronze PPO

Groups Beginning 4.1.2025

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Acupuncture	65%	Not Covered	65%	Not Covered
Physical, Occupational, Speech Therapy	65%	50% [14]	65%	50% [14]
Rehabilitative & Habilitative Services and Devices	65% [11]	50% [11]	65% [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [12]	50% (up to $150 per day) [5, 12]	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health				
In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
Out-Patient (office visit)	65%	50%	65%	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	65% [7]	50% [7]	65% [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	None	None	None	None
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%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

(Footnotes continued on page 87)

Bronze PPO

Groups Beginning 4.1.2025

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$6,000 / $12,000 (applies to Max OOP)	$12,000 / $24,000 (applies to Max OOP)	$6,000 / $12,000 (applies to Max OOP)	$12,000 / $24,000 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,500 / $17,000 [1]	$17,000 / $34,000 [1]	$8,500 / $17,000 [1]	$17,000 / $34,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$65 Copay	50%	$65Copay	50%
Specialist Visit (SPC)	$85 Copay	50%	$85 Copay	50%
Laboratory	60%	50%	60%	50%
X-Ray	60%	50%	60%	50%
MRI, CT and PET (office setting)	60% [14]	50% (up to $800 per test) [5]	60% [14]	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	$65 Copay / $85 Copay [15]	50%	$65 Copay / $85 Copay [15]	50%
Hospital Services –In-Patient	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
In-Patient Physician Fees	60%	50%	60%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 60%		$250 Copay – 60%	
Urgent Care	$65 Copay	50%	$65 Copay	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit - 60% $50 Copay per admit - 60%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit - 60% $50 Copay per admit - 60%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$85 Copay	50%	$85 Copay	50%
Ambulance Services (per trip)	60% [13]		60% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $20 Copay / Level 2 $20 Copay (ded waived) [2] $650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay [2] $650 / $1,300 Ded - Level 1 $160 Copay / Level 2 $170 Copay [2] $650 / $1,300 Ded - Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (prior auth. required) [2,6]	 Not Covered Not Covered Not Covered]Not Covered	 Level 1 $20 Copay / Level 2 $20 Copay (ded waived) [2] $650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay [2] $650 / $1,300 Ded - Level 1 $160 Copay / Level 2 $170 Copay [2] $650 / $1,300 Ded - Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (prior auth. required) [2,6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
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 [16]		Covered [16]	
Chemotherapy	60%	50% [14]	60%	50% [14]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$65 Copay	Not Covered	$65 Copay	Not Covered

Bronze PPO

Groups Beginning 4.1.2025

Services	**PPO C**		**PPO D**	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Physical, Occupational, Speech Therapy	60%	50% [14]	60%	50% [14]
Rehabilitative & Habilitative Services and Devices	60% [11]	50% [11]	60% [11]	50% [11]
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	60% (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)	60% [12]	50% (up to $150 per day) [5, 12]	60% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health				
In-Patient	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
Out-Patient (office visit)	60%	50%	60%	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	$65 Copay [7]	50% [7]	$65 Copay [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 (ded waived)	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
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	None	None	None	None
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%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

(Footnotes continued on page 87)

Additional Footnotes

Groups Beginning 4.1.2025

Gold PPO

(Footnotes continued from page 54)

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.

Gold PPO

(Footnotes continued from page 56)

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.

Silver HMO

(Footnotes continued from page 58)

21. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
22. 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.
23. Must be medically necessary.
24. Pediatric dental and vision are included on all plans.

Silver HMO

(Footnotes continued from page 64)

12. Refers to procedure code D8080/D8090
13. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for autism spectrum disorder.
14. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
15. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every calendar year.
16. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.
17. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
18. 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.
19. Amount listed for In-Patient Services only.
20. Refers to procedure codes D0120 and D1120/D1110

Additional Footnotes

Groups Beginning 4.1.2025

Silver HMO

(Footnotes continued from page 66)

12. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plan pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plan pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plan pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,300 for 2025 plans.
13. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for autism spectrum disorder.
14. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
15. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every calendar year.
16. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.

Silver PPO

(Footnotes continued from page 74)

† HSA Qualified High Deductible Plan

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of- Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.
17. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Silver PPO

(Footnotes continued from page 72)

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.

Additional Footnotes

Groups Beginning 4.1.2025

Bronze HMO

(Footnotes continued from page 78)

9. Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk-in Care visits.
10. In a high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum work differently. In a Self-Only coverage plan, you must meet the Self-Only Deductible and the Self -Only Out-of-Pocket Maximum. Once you meet the Self-Only Deductible, Sharp Health Plan will pay for your services. The Self-Only Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In a Family plan, each individual in the family must meet the Individual Deductible until the Family Deductible is met. Once an individual meets the Individual Deductible, Sharp Health Plan will pay for services for that individual in the family. Once the Family Deductible is met, Sharp Health Plan will pay for services for the entire family. All family members have met the Family Out-of-Pocket Maximum when the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum.
11. Copayment depends on type and location of service.
12. Refers to procedure code D2140
13. Refers to procedure code D3330
14. Refers to procedure code D0999
15. Maximum member responsibility.
16. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for autism spectrum disorder.
17. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
18. Refers to procedure codes D0120 and D1120/D1110
19. Refers to procedure code D8080/D8090

Bronze PPO

(Footnotes continued from page 82)

† HSA Qualified High Deductible Plan

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/ services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.

(continued in next column)

Bronze PPO - *continued*

(Footnotes continued from page 82)

16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.
17. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Bronze PPO

(Footnotes continued from page 84)

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
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.
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10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
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16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.

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