Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4/1/19

Bronze

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

Bronze HMO & HSP

Groups Beginning 4/1/19

Services	HSP A	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	PureCare	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,000 / $10,000 (applies to Max OOP)	$6,300 / $12,600 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,150 / $14,300	$7,550 / $15,100
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay [1]	$75 Copay [9]
Specialist Visit (SPC)	$60 Copay [1]	$105 Copay [9]
Laboratory	50%	$40 Copay (ded waived)
X-Ray	50%	100% [10]
MRI, CT and PET (office setting)	50%	100% [10]
Hospital Services – In-Patient	50%	100% [10]
In-Patient Physician Fees	50%	100% [10]
Emergency Room (copay waived if admitted)	50%	100% [10]
Urgent Care	$60 Copay	$75 Copay [9]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 50% 50% [11]	 100% [10] 100% [10]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$60 Copay	100% [10]
Ambulance Services (per trip)	50%	100% [10]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) $500 / $1,000 Ded – $45 Copay $500 / $1,000 Ded – 50% (up to $500 per prescription [6]) $500 / $1,000 Ded – 50% (up to $500 per prescription [6])	 $500 Ded – 100% (up to $500 per prescription [6]) [10] $500 Ded – 100% (up to $500 per prescription [6]) [10] $500 Ded – 100% (up to $500 per prescription [6]) [10] $500 Ded – 100% (up to $500 per prescription [6])(with physician approval) [10]
Oral Contraceptives	100%	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – 50%	100% (up to $500 per prescription [6]) [10]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any illness
Preventive/Wellness Services	100% (ded waived) [4]	100% (ded waived) [4]
Chronic Disease Management	$60 Copay	100% [10]
Chemotherapy	50%	100% [10]
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	$10 Copay	$75 Copay [9]
Physical, Occupational, Speech Therapy	$45 Copay	$75 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$45 Copay	$75 Copay (ded waived)

Services	HSP A	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	PureCare	Full
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	50%	100% [10]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50% (no limit)	100% [10]
Hospice (out-patient)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	100% [10]
Mental Health In-Patient Out-Patient (office visit)	 50% $45 Copay	 100% [10] $75 Copay [9]
Drug/Substance Abuse In-Patient (Detox Only)	 50%	 100% [10]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% [2] 50% [2] Not Covered 50% [2] Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [3] EyeMed 100% 100% 1 pair per calendar year None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [12] 1 pair per calendar year [12] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [3, 5] Dental Benefit Providers None None 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $95 Copay [7] $365 Copay [8] $350 Copay

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

1. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
2. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
3. Pediatric dental and vision are included on all plans.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
6. Maximum member responsibility.
7. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
8. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
9. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).
10. Covered in full after out-of-pocket maximum is met.
11. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
12. 1 pair of glasses or 1 pair of contact lenses per accumulation period.

Bronze HMO

Groups Beginning 4/1/19

Services	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,000 / $12,000 (combined Med/Rx ded)(applies to Max OOP)	$6,900 / $13,800 [4] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,650 / $13,300	$7,900 / $15,800 [4, 11]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$60 Copay
Specialist Visit (SPC)	60%	$75 Copay
Laboratory	60%	$60 Copay
X-Ray	60%	$100 Copay
MRI, CT and PET (office setting)	60% per procedure	$400 Copay per procedure
Hospital Services – In-Patient	60%	$1,500 Copay per day – 3 days max
In-Patient Physician Fees	60%	100%
Emergency Room (copay waived if admitted)	60%	$500 Copay
Urgent Care	60%	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	60%	$75 Copay
Ambulance Services (per trip)	60%	$500 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% (up to $500 per prescription [9]) (combined Med/Rx ded) 60% (up to $500 per prescription [9]) (combined Med/Rx ded) 60% (up to $500 per prescription [9]) (combined Med/Rx ded) (with physician approval) 60% (up to $500 per prescription [9]) (combined Med/Rx ded) (with physician approval)	 $19 Copay (ded waived) $60 Copay (combined Med/Rx ded) $100 Copay (combined Med/Rx ded) Applicable Rx Copay (combined Med/Rx ded)
Oral Contraceptives	100%	100% (if in formulary)
Diabetes – Self-Injectable	60% (up to $500 per prescription [9]) (combined Med/Rx ded)	Applicable Rx Copay (combined Med/Rx ded)
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	60%	$75 Copay
Chemotherapy	60%	Variable [8]
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	60%	$60 Copay
Physical, Occupational, Speech Therapy	60%	$60 Copay

Services	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Rehabilitative & Habilitative Services and Devices	60%	$60 Copay
Home Health Care (Max 100 visits per year)	60%[1]	$60 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	$200 Copay per day
Hospice (out-patient)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%[6]	50%
Mental Health In-Patient Out-Patient (office visit)	 60% 60%	 $1,500 Copay per day – 3 days max $60 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 $1,500 Copay per day – 3 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year[10] 1 pair per calendar year (ded waived)[10] None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay[2] $365 Copay[3] $350 Copay	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700[7] 100% 100% $25 Copay[2] $350 Copay[3] $350 Copay

† HSA Qualified High Deductible Plan

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

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

Bronze HMO

Groups Beginning 4/1/19

Services	HMO B† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sutter Health Plus
Network Name	Performance	Sutter Health Plus
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,650 / $11,300 [10] (combined Med/Rx ded)(applies to Max OOP)	$6,300 / $12,600 [1] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,650 / $13,300 [10, 17]	$7,550 / $15,100 [2]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$75 Copay [8, 9]
Specialist Visit (SPC)	60%	$105 Copay [8]
Laboratory	60%	$40 Copay (ded waived)
X-Ray	60%	100% [18]
MRI, CT and PET (office setting)	60%	100% [18]
Hospital Services – In-Patient	60%	100% [18]
In-Patient Physician Fees	60%	100% [18]
Emergency Room (copay waived if admitted)	60%	100% [18]
Urgent Care	60%	$75 Copay [8]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 100% [18] 100% [18]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	60%	$105 Copay [8]
Ambulance Services (per trip)	60%	100% [18]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded)	 $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3] $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3, 4]
Oral Contraceptives	100% (if in formulary)	100% (ded waived)
Diabetes – Self-Injectable	60% (up to $500 per prescription [15]) (combined Med/Rx ded)	$500 / $1,000 Ded – Applicable Rx Copay [3]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	60%	Covered as any Illness
Chemotherapy	Variable [11]	100% [18]
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	60%	$75 Copay [8]
Physical, Occupational, Speech Therapy	60%	$75 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	60%	$75 Copay (ded waived)
Home Health Care (Max 100 visits per year)	60%	100% [18]

Services	HMO B† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sutter Health Plus
Network Name	Performance	Sutter Health Plus
Metal Tier	**Bronze**	**Bronze**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100% [18]
Hospice (out-patient)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	100% [18]
Mental Health In-Patient Out-Patient (office visit)	 60% 60%	 100% [16, 18] $75 Copay [8]
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 100% [16, 18]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [6] 100% (in lieu of eyeglasses) (ded waived) [6, 7] 100% (in lieu of contact lenses) (ded waived) [6, 7] 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [14] 100% 100% $25 Copay [12] $350 Copay [13] $350 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)

† HSA Qualified High Deductible Plan

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

1. Family deductibles (when applicable) and out-of-pocket maximums (OOPM) are "embedded". This means that an individual in a family plan is responsible for no more than the "individual family member" deductible and OOPM (please see exceptions below regarding high deductible health plans (HDHPs). Once an individual family member has met their deductible, that family member will only be responsible for the specified copayment or coinsurance until that individual meets the individual family member OOPM or the family as a whole meets the family OOPM, whichever comes first. Deductibles and other cost sharing payments made by each individual in a family accrue to both the "family" deductible and "family" OOPM. Once the family deductible has been met, individual family members who have not yet met the individual family member OOPM amount will continue to be responsible for the specified copayment or coinsurance until they meet the individual family member OOPM or until the family as a whole meets the "family" OOPM, at which point, Sutter Health Plus pays all costs for covered services for all family members. For HDHPs, in a family plan, an individual family member's deductible must be the higher of the specified "single" deductible amount or the IRS minimum of $2,700 for 2019 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
2. Cost sharing for all essential health benefits, including that which accumulates toward an applicable deductible, accumulates toward the out-of-pocket maximum.
3. Copayments apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription for up to a 30-day supply. For HDHP plans, this $200 maximum will not apply until after the deductible is met.
4. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members through the end of the month in which the member turns 19 years of age as part of the essential health benefit for pediatric vision.
7. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
8. When outpatient benefits have Cost Sharing that includes "deductible waived for 1st 3 non-preventive visits", the Deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient MH/SUD visits.
9. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
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.

(Footnotes continued on page 14)

Bronze HMO

Groups Beginning 4/1/19

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

Services	HMO B† HSA Qualified	HMO B† HSA Qualified
Participating Health Plans	Sutter Health Plus	UnitedHealthcare
Network Name	Sutter Health Plus	Alliance
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100%
Hospice (out-patient)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	60%	100%
Mental Health In-Patient Out-Patient (office visit)	 60% [14] 60%	 100% 100%
Drug/Substance Abuse In-Patient (Detox Only)	 60% [14]	 100%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% (ded waived) [11] 100% (in lieu of eyeglasses) (ded waived) [11, 12] 100% (in lieu of contact lenses) (ded waived) [11, 12] 1 pair per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 100% 100% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)	 UnitedHealthcare Dental CA DHMO Combined Med/Rx/Pediatric dental ded Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
3. Family deductibles (when applicable) and out-of-pocket maximums (OOPM) are "embedded". This means that an individual in a family plan is responsible for no more than the "individual family member" deductible and OOPM (please see exceptions below regarding high deductible health plans (HDHPs). Once an individual family member has met their deductible, that family member will only be responsible for the specified copayment or coinsurance until that individual meets the individual family member OOPM or the family as a whole meets the family OOPM, whichever comes first. Deductibles and other cost sharing payments made by each individual in a family accrue to both the "family" deductible and "family" OOPM. Once the family deductible has been met, individual family members who have not yet met the individual family member OOPM amount will continue to be responsible for the specified copayment or coinsurance until they meet the individual family member OOPM or until the family as a whole meets the "family" OOPM, at which point, Sutter Health Plus pays all costs for covered services for all family members. For HDHPs, in a family plan, an individual family member's deductible must be the higher of the specified "single" deductible amount or the IRS minimum of $2,700 for 2019 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
4. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
5. Cost sharing for all essential health benefits, including that which accumulates toward an applicable deductible, accumulates toward the out-of-pocket maximum.
6. For Specialty drugs, please see plan specific EOC.
7. For instances where the contracted rate is less than your copayment, you will only pay the contracted rate.
8. Maximum member responsibility.
9. Copayments apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription for up to a 30-day supply. For HDHP plans, this $200 maximum will not apply until after the deductible is met.

(Footnotes continued on page 14)

Bronze HMO

Groups Beginning 4/1/19

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 [1, 7] (applies to Max OOP)	$6,500 / $13,000 [1, 7] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,550 / $15,100 [2, 7]	$6,500 / $13,000 [2, 7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$75 Copay [9]	100% [1]
Specialist Visit (SPC)	$105 Copay [9]	100% [1]
Laboratory	$40 Copay (ded waived)	100% [1]
X-Ray	100% [1, 11]	100% [1]
MRI, CT and PET (office setting)	100% [1, 11]	100% [1]
Hospital Services – In-Patient	100% [1, 11]	100% [1]
In-Patient Physician Fees	100% [1, 11]	100% [1]
Emergency Room (copay waived if admitted)	100% [1, 11]	100% [1]
Urgent Care	$75 Copay [1]	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% [1, 11] 100% [1, 11]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$105 Copay [9]	100% [1]
Ambulance Services (per trip)	100% [1, 11]	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1] $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1, 13] $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1, 13] $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1]	 100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 13] 100% (combined Med/Rx ded) [1, 13] 100% (combined Med/Rx ded) [1]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1]	100% (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	100% [1, 11]	100% [1]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$75 Copay [1]	100% [1]
Physical, Occupational, Speech Therapy	$75 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$75 Copay (ded waived)	100% [1]
Home Health Care (Max 100 visits per year)	100% [1, 11]	100% [1]

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

† HSA Qualified High Deductible Plan

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

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

Bronze EPO

Groups Beginning 4/1/19

Services	EPO A	EPO A† HSA Qualified	EPO B
Participating Health Plans	Anthem Blue Cross	Oscar	Oscar
Network Name	Prudent Buyer – Small Group	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,600 / $11,200 [1] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$6,650 / $13,300 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$7,900 / $15,800 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,900 / $15,800 [2]	$6,650 / $13,300	$7,900 / $15,800
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay (first 3 visits) [8] – $65 Copay	100%	100%
Specialist Visit (SPC)	$85 Copay (first 3 visits) [8] – $85 Copay	100%	100%
Laboratory	60%	100%	100%
X-Ray	60%	100% [19]	100% [19]
MRI, CT and PET (office setting)	60% [14]	100% [19]	100% [19]
Hospital Services – In-Patient	60%	100%	100%
In-Patient Physician Fees	60%	100%	100%
Emergency Room (copay waived if admitted)	$300 Copay – 60%	100%	100%
Urgent Care	60%	100%	$75 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 100% 100%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$85 Copay (first 3 visits) [8] – $85 Copay	100% [18]	100% [18]
Ambulance Services (per trip)	60% [10]	100%	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay / $20 Copay (ded waived) [9] $60 Copay (combined Med/Rx/Pediatric dental ded) [9] $100 Copay (combined Med/Rx/Pediatric dental ded) [9] 70% (up to $500 per prescription [3]) (prior auth. required) (combined Med/Rx/Pediatric dental ded) [4, 9]	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [9]	Applicable Ded/Rx Copay	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [6]	100% (ded waived) [6]	100% (ded waived) [6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	60%	100%	100%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	100% [22]	100% [22]
Acupuncture	60%	100%	100%
Physical, Occupational, Speech Therapy	60%	100%	100%
Rehabilitative & Habilitative Services and Devices	60% [12]	100% [16]	100% [16]

Services	EPO A	EPO A† HSA Qualified	EPO B
Participating Health Plans	Anthem Blue Cross	Oscar	Oscar
Network Name	Prudent Buyer – Small Group	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [5]	100%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% [13]	100%	100%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	100% [20]	100% [20]
Mental Health In-Patient Out-Patient (office visit)	 60% 60%	 100% 100%	 100% 100%
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 100%	 100%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $65 Copay (first 3 visits) [8] – $65 Copay [7] Not Covered Not Covered Not Covered Not Covered	 See Plan Specific EOC [17] Not Covered Not Covered Not Covered Not Covered	 See Plan Specific EOC [17] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year	 Oscar Davis Vision 100% [15, 21] 100% (only in lieu of eyeglasses) 100% 1 pair per calendar year	 Oscar Davis Vision 100% [15, 21] 100% (only in lieu of eyeglasses) 100% 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded Combined with Medical 100% 100% (ded waived) 50% 50% 50%	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [15] Copay varies by service Copay varies by service (prior auth. required) 100% (prior auth. required)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [15] Copay varies by service Copay varies by service (prior auth. required) 100% (prior auth. required)

† HSA Qualified High Deductible Plan

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

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

(Footnotes continued on page 14)

Additional Footnotes

Groups Beginning 4/1/19

Bronze HMO

(Footnotes continued from page 7)

11. Copayment depends on type and location of service.
12. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
13. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
14. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children
15. Maximum member responsibility.
16. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
17. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum
18. Covered in full after out-of-pocket maximum is met..

Bronze EPO

(Footnotes continued from page 13)

17. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
18. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
19. Prior-Authorization may be required.
20. Prior-Authorization required if annual cost is greater than $500.
21. Limit one exam per 12 months.
22. No limit on the number of visits per year. Please see plan documents for more information.

Bronze HMO

(Footnotes continued from page 9)

10. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
11. Pediatric eye exam and glasses or contact lenses are provided annually for members through the end of the month in which the member turns 19 years of age as part of the essential health benefit for pediatric vision.
12. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
13. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
14. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.

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