Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 1/1/18

(Revised 10/26/17)

Bronze

CaliforniaChoice®

Your Health. Your Choice.®

Anthem BlueCross · Health Net · KAISER PERMANENTE · SHARP HEALTH PLAN · Sutter Health Plus Your Health Plan · UnitedHealthcare · Western Health Advantage

Jan – June 2018 Benefit Update

Due to recent changes required by the California Department of Managed Health Care, we have an update to our January through June 2018 benefits.

Below is an overview of the previous benefit and updated benefit.

Health Plan	Benefit Plan	Jan-June 2018 Quote	Benefit Update
Sharp Health Plan	Silver HMO A	Calendar Year Deductible: $2,600/$5,200 (applies to Max OOP)	**Calendar Year Deductible: $2,100/$4,200 (applies to Max OOP)**
Sharp Health Plan	Bronze HMO A	Specialist Visit (SPC): $100 Copay	**Specialist Visit (SPC): $75 Copay**
Sharp Health Plan	Bronze HMO A	Urgent Care: $100 Copay	**Urgent Care: $75 Copay**

If you have any questions regarding the updates, please contact our Customer Service department at 800.558.8003. Thank you for choosing California*Choice*®. We appreciate your business.

CONTENTS

Groups Beginning 1/1/18

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 1/1/18

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	$7,000 / $14,000
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	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% 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 1/1/18

Services	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$4,800 / $9,600 (combined Med/ Rx ded)(applies to Max OOP)	$3,200 / $6,400 [4] (combined Med/ Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,550 / $13,100	$5,700 / $11,400 [4]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$60 Copay
Specialist Visit (SPC)	60%	$100 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%	$100 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	60%	$100 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%	$100 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	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. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
5. See plan specific EOC information on preventive services.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. The pediatric dental out-of-pocket maximum is $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.

Bronze HMO

Groups Beginning 1/1/18

Services	HMO B† HSA Qualified	HMO D† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Full
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$4,750 / $9,500 [10] (combined Med/Rx ded)(applies to Max OOP)	$3,500 / $7,000 [19] (combined Med/Rx ded) (applies to Max OOP)	$6,300 / $12,600 [1] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,550 / $13,100 [10]	$5,800 / $11,600 [19, 20]	$7,000 / $14,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$60 Copay	$75 Copay [8, 9]
Specialist Visit (SPC)	60%	$120 Copay	$105 Copay [8]
Laboratory	60%	50%	$40 Copay (ded waived)
X-Ray	60%	50%	100% [18]
MRI, CT and PET (office setting)	60%	50%	100% [18]
Hospital Services – In-Patient	60%	50%	100% [18]
In-Patient Physician Fees	60%	50%	100% [18]
Emergency Room (copay waived if admitted)	60%	50%	100% [18]
Urgent Care	60%	$120 Copay	$75 Copay [8]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 50% 50%	 100% [18] 100% [18]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	$120 Copay	$105 Copay [8]
Ambulance Services (per trip)	60%	50%	100% [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)	 $30 Copay (combined Med/Rx ded) $70 Copay (combined Med/Rx ded) $100 Copay (combined Med/Rx ded) Applicable Rx Copay (combined Med/Rx ded)	 $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3] $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 100% [18] (up to $500 per prescription [15]) [3, 4]
Oral Contraceptives	100% (if in formulary)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	60% (up to $500 per prescription [15]) (combined Med/Rx ded)	Applicable Rx Copay (combined Med/Rx ded)	$500 / $1,000 Ded – Applicable Rx Copay [3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	60%	$120 Copay	Covered as any Illness
Chemotherapy	Variable [11]	Variable [21]	100% [18]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	60%	$60 Copay	$75 Copay [8]
Physical, Occupational, Speech Therapy	60%	$60 Copay	$75 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	60%	$60 Copay	$75 Copay (ded waived)
Home Health Care (Max 100 visits per year)	60%	$60 Copay	100% [18]

Services	HMO B† HSA Qualified	HMO D† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Full
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	50%	100% [18]
Hospice	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	100% [18]
Mental Health In-Patient Out-Patient (office visit)	 60% 60%	 50% $60 Copay	 100% [16, 18] $75 Copay [8, 17]
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 50%	 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	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [6] 100% (in lieu of eyeglasses; ded waived) [6, 7] 100% (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	 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 and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or $2,700 for the 2018 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
2. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
3. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP Plans, this applies after the deductible is met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day Copay price, through the mail-order form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
4. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members 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. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
8. Deductible is waived for the first three non-preventive visits (combined for primary care, specialist, urgent care, acupuncture and outpatient mental health or substance use disorder office visits).
9. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
10. In high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of Pocket Maximum.

(Footnotes continued on page 16)

Bronze HMO

Groups Beginning 1/1/18

Services	HMO B† HSA Qualified	HMO B† HSA Qualified	HMO C
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	Alliance	Alliance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$4,800 / $9,600[3] (combined Med/Rx ded) (applies to Max OOP)	$6,500 / $13,000[2] (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)	$6,250 / $12,500[2] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,550 / $13,100[5]	$6,500 / $13,000[4]	$7,350 / $14,700[4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%[13]	100%	70%
Specialist Visit (SPC)	60%	100%	70%
Laboratory	60%	100%	70%
X-Ray	60%	100%	70%
MRI, CT and PET (office setting)	60%	100%	70%
Hospital Services – In-Patient	60%	100%	70%
In-Patient Physician Fees	60%	100%	70%
Emergency Room (copay waived if admitted)	60%	100%	70%
Urgent Care	60%	100%	70%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 100% 100%	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	100%	70%
Ambulance Services (per trip)	60%	100%	70%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% (up to $500 per prescription[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]	 $25 Copay (ded waived) $250 / $500 Ded – $100 Copay[6] $250 / $500 Ded – $150 Copay[6] $250 / $500 Ded – 70% (up to $500 per prescription[8])[6]
Oral Contraceptives	100% (ded waived)	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]	$250 / $500 Ded – Application Rx Copay[6]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[1]	100% (ded waived)[1]	100% (ded waived)[1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	60%	100%	70%[7]
Chiropractic (20 visits max per year)	Not Covered	100%	70%
Acupuncture	60%	100%	70%
Physical, Occupational, Speech Therapy	60%	100%	70%
Rehabilitative & Habilitative Services and Devices	60%	100%	70%

Services	HMO B† HSA Qualified	HMO B† HSA Qualified	HMO C
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	Alliance	Alliance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	100%	70%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	60%	100%	70%
Mental Health In-Patient Out-Patient (office visit)	 60% [14] 60% [15]	 100% 100%	 70% 70%
Drug/Substance Abuse In-Patient (Detox Only)	 60% [14]	 100%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 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% (ded waived) [11, 12] 1 pair per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 100% 100% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) 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	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
3. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or $2,700 for the 2018 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
4. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
5. Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
6. For Specialty drugs, please see plan specific EOC.
7. For instances where the contracted rate is less than your copayment, you will only pay the contracted rate.
8. Maximum member responsibility.
9. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP Plans, this applies after the deductible is met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day Copay price, through the mail-order form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.

(Footnotes continued on page 16)

Bronze HMO

Groups Beginning 1/1/18

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	$7,000 / $14,000 [2, 7]	$6,500 / $13,000 [2, 7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$75 Copay [9]	100% [1]
Specialist Visit (SPC)	$105 Copay [9]	100% [1]
Laboratory	$40 Copay (ded waived)	100% [1]
X-Ray	100% [1, 11]	100% [1]
MRI, CT and PET (office setting)	100% [1, 11]	100% [1]
Hospital Services – In-Patient	100% [1, 11]	100% [1]
In-Patient Physician Fees	100% [1, 11]	100% [1]
Emergency Room (copay waived if admitted)	100% [1, 11]	100% [1]
Urgent Care	$75 Copay [1]	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% [1, 11] 100% [1, 11]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$105 Copay [9]	100% [1]
Ambulance Services (per trip)	100% [1, 11]	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1] $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1, 13] $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1, 13] $500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1]	 100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 13] 100% (combined Med/Rx ded) [1, 13] 100% (combined Med/Rx ded) [1]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1]	100% (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	100% [1, 11]	100% [1]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	Not Covered
Acupuncture	$75 Copay [1]	100% [1]
Physical, Occupational, Speech Therapy	$75 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$75 Copay (ded waived)	100% [1]
Home Health Care (Max 100 visits per year)	100% [1, 11]	100% [1]

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100% [1, 11]	100% [1]
Hospice	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	100% [1, 5, 11]	100% [1]
Mental Health In-Patient 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 HMO

Groups Beginning 1/1/18

Services	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Bronze**
Calendar Year Deductible*	$4,800 / $9,600 [1, 7] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,550 / $13,100 [2, 7]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	60% [1, 4]
Specialist Visit (SPC)	60% [1, 4]
Laboratory	60% [1, 4]
X-Ray	60% [1, 4]
MRI, CT and PET (office setting)	60% [1, 4]
Hospital Services – In-Patient	60% [1, 4]
In-Patient Physician Fees	60% [1, 4]
Emergency Room (copay waived if admitted)	60% [1, 4]
Urgent Care	60% [1, 4]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]
Hospital Pre-Authorization	Required
2nd Surgical Opinion	60% [1, 4]
Ambulance Services (per trip)	60% [1, 4]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% (up to $500 per 30 day supply [9]) (combined Med/Rx ded) [1, 4] 60% (up to $500 per 30 day supply [9]) (combined Med/Rx ded) [1, 4, 10] 60% (up to $500 per 30 day supply [9]) (combined Med/Rx ded) [1, 4, 10] 60% (up to $500 per 30 day supply [9]) (combined Med/Rx ded) [1, 4]
Oral Contraceptives	100% (ded waived)
Diabetes – Self-Injectable	60% (up to $500 per 30 day supply [9]) (combined Med/Rx ded) [1, 4]
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness
Chemotherapy	60% [1, 4]
Chiropractic (20 visits max per year)	100% [1, 11]
Acupuncture	60% [1, 4]
Physical, Occupational, Speech Therapy	60% [1, 4]
Rehabilitative & Habilitative Services and Devices	60% [1, 4]

Services	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Bronze**
Home Health Care (Max 100 visits per year)	60% [1, 4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% [1, 4]
Hospice	100% [1]
Durable Medical Equipment (Covered when medically necessary)	60% [1, 4, 5]
Mental Health In-Patient Out-Patient (office visit)	 60% [1, 4] 60% [1, 4]
Drug/Substance Abuse In-Patient (Detox Only)	 60% [1, 4]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [8]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

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

Bronze EPO

Groups Beginning 1/1/18

Services	EPO A
Participating Health Plans	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group
Metal Tier	**Bronze**
Calendar Year Deductible*	$5,600 / $11,200 [1] (combined Med/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [2]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	$65 Copay (first 3 visits) [8] – 60%
Specialist Visit (SPC)	$65 Copay (first 3 visits) [8] – 60%
Laboratory	60%
X-Ray	60%
MRI, CT and PET (office setting)	60% [14]
Hospital Services – In-Patient	$1,000 Copay per admit
In-Patient Physician Fees	60%
Emergency Room (copay waived if admitted)	$400 Copay – 60%
Urgent Care	60%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay per admit – 60% $500 Copay per admit – 60%
Hospital Pre-Authorization	Required
2nd Surgical Opinion	$65 Copay (first 3 visits) [8] – 60%
Ambulance Services (per trip)	60% [10]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay / $20 Copay (ded waived) [9] $500 / $1,000 Ded – $60 Copay [9] $500 / $1,000 Ded – $100 Copay [9] $500 / $1,000 Ded – 70% (up to $250 per prescription [3]) (prior auth. required) [4, 9]
Oral Contraceptives	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [9]
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [6]
Chronic Disease Management	Covered as any Illness
Chemotherapy	60%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]
Acupuncture	60%
Physical, Occupational, Speech Therapy	60%
Rehabilitative & Habilitative Services and Devices	60% [12]

Services	EPO A
Participating Health Plans	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group
Metal Tier	**Bronze**
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$1,000 Copay per admit [13]
Hospice	100%
Durable Medical Equipment (Covered when medically necessary)	50%
Mental Health In-Patient Out-Patient (office visit)	 $1,000 Copay per admit $65 Copay (first 3 visits) [8] – 60%
Drug/Substance Abuse In-Patient (Detox Only)	 $1,000 Copay per admit
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $65 Copay (first 3 visits) [8] – 60% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% (ded waived) 50% 50% 50%

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

1. 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, Retail Health Clinic Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
9. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
10. Medical emergency only.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Additional Footnotes

Groups Beginning 1/1/18

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 Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
17. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.
18. Covered in full after out-of-pocket maximum is met.
19. In high deductible health plans (HDHPs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.
20. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
21. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.

Bronze HMO

(Footnotes continued from page 9)

10. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.
11. Pediatric eye exam and glasses or contact lenses are provided annually for members 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. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
13. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
14. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
15. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.

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