

# Benefit Summaries

**Small Business Private Exchange**

For Groups of 1-100 Employees

Groups Beginning 10/1/17

**Gold/Silver**



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

# Gold HMO

Groups Beginning 10/1/17

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

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

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

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



# Gold HMO & HSP

Groups Beginning 10/1/17

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

# Gold HMO & HSP

## Groups Beginning 10/1/17

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

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

1. Must be medically necessary.
2. Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.
3. See plan specific EOC for information on preventive services.
4. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
5. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
6. The brand-name prescription drug deductible (per member, per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs.

7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Pediatric dental and vision are included on all plans.
10. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
11. Maximum member responsibility.



# Gold HMO

Groups Beginning 10/1/17

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

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Performance
<b>Metal Tier</b>	<b>Gold</b>	<b>Gold</b>	<b>Gold</b>
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$300 Copay per day – 5 days max	\$300 Copay per day – 5 days max	70%
Hospice	100% (ded waived)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) <sup>8</sup>	80% <sup>8</sup>	50%
<b>Mental Health</b> In-Patient Out-Patient (office visit)	\$600 Copay per day – 5 days max \$30 Copay (ded waived)	\$600 Copay per day – 5 days max \$30 Copay	70% \$20 Copay
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	\$600 Copay per day – 5 days max	\$600 Copay per day – 5 days max	70%
<b>Infertility</b> 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
<b>Pediatric Vision</b> Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) None	Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year 1 pair per calendar year None	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
<b>Pediatric Dental</b> 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) \$40 Copay <sup>2</sup> \$365 Copay <sup>3</sup> \$350 Copay	Delta Dental DeltaCare USA None \$350 / \$700 100% 100% \$40 Copay <sup>2</sup> \$365 Copay <sup>3</sup> \$350 Copay	Premier Access Access Dental DHMO None \$1,000 / \$2,000 <sup>9</sup> \$20 Copay 100% \$95 Copay <sup>2</sup> \$365 Copay <sup>3</sup> \$1,000 Copay

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

- 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).
- 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.
- 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.
- 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.
- See plan specific EOC for information on preventive services.

- Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
- Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
- 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.
- The pediatric dental out-of-pocket maximum is \$1,000 for a family with one child and \$2,000 for a family with 2 or more children.
- Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
- Maximum member responsibility.





# Gold HMO

Groups Beginning 10/1/17

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

Services	HMO B	HMO C	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Premier	Premier	Full
<b>Metal Tier</b>	<b>Gold</b>	<b>Gold</b>	<b>Gold</b>
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$200 Copay per day	50%	80%
Hospice	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	80%
<b>Mental Health</b> In-Patient Out-Patient (office visit)	\$600 Copay per day – 5 days max \$25 Copay	50% \$10 Copay (ded waived)	80% <sup>15</sup> \$30 Copay <sup>16</sup>
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	\$600 Copay per day – 5 days max	50%	80% <sup>15</sup>
<b>Infertility</b> 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
<b>Pediatric Vision</b> 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) <sup>11</sup> 100% (in lieu of eyeglasses; ded waived) <sup>11, 12</sup> 100% (ded waived) <sup>11, 12</sup> 1 pair per year
<b>Pediatric Dental</b> Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Premier Access Access Dental DHMO None \$1,000 / \$2,000 <sup>5</sup> \$20 Copay 100% \$95 Copay <sup>1</sup> \$365 Copay <sup>2</sup> \$1,000 Copay	Premier Access Access Dental DHMO None \$1,000 / \$2,000 <sup>5</sup> \$20 Copay 100% \$95 Copay <sup>1</sup> \$365 Copay <sup>2</sup> \$1,000 Copay	Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) \$25 Copay (ded waived) Copay varies by service (ded waived) \$1,000 Copay (ded waived)

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

- 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.
- 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.
- 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.
- See plan specific EOC for information on preventive services.
- The pediatric dental out-of-pocket maximum is \$1,000 for a family with one child and \$2,000 for a family with 2 or more children.
- Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
- Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family

- Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or \$2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
- Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
- Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
- 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.
- Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
- Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.

(Foot notes continued on page 38)



# Gold HMO

Groups Beginning 10/1/17

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

Services	HMO B	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Alliance
<b>Metal Tier</b>	<b>Gold</b>	<b>Gold</b>	<b>Gold</b>
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$300 Copay per day – 5 days max	70%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80%	\$50 Copay	\$50 Copay
<b>Mental Health</b> In-Patient Out-Patient (office visit)	\$600 Copay per day – 5 days max <sup>13</sup> \$30 Copay <sup>14</sup>	70% \$50 Copay	70% \$50 Copay
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	\$600 Copay per day – 5 days max <sup>13</sup>	70%	70%
<b>Infertility</b> Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	50% See Plan Specific EOC Not Covered 50% <sup>5</sup> Not Covered	50% See Plan Specific EOC Not Covered 50% <sup>5</sup> Not Covered
<b>Pediatric Vision</b> Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	VSP Choice Network 100% <sup>11</sup> 100% (in lieu of eyeglasses) <sup>11, 12</sup> 100% <sup>11, 12</sup> 1 pair per year	UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year	UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year
<b>Pediatric Dental</b> 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% \$25 Copay Copay varies by service \$1,000 Copay	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay

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

- See plan specific EOC for information on preventive services.
- 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.
- For Specialty drugs, please see plan specific EOC.
- In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
- Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
- Maximum member responsibility.
- Cost sharing amounts for all essential health benefits, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
- 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.
- Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
- 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.
- Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
- Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
- 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.
- Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.



# Gold HMO

Groups Beginning 10/1/17

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

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

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

- The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
- There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
- Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
- See copayment summary for applicable prosthetic/orthotic device copayment amount.
- See plan specific EOC for information on preventive services.
- When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.

7. For Specialty drugs, please see plan specific EOC.

- In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
- Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
- Maximum member responsibility.
- Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
- Copayments do not contribute to out-of-pocket maximum.
- Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.



# Gold HMO

Groups Beginning 10/1/17

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



Services	HMO C	HMO D†	HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	
Network Name	Full	Full	
<b>Metal Tier</b>	<b>Gold</b>	<b>Gold</b>	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$500 Copay per day <sup>1</sup> – Days 1-5	100% <sup>1</sup>	
Hospice	100% (ded waived)	100% <sup>1</sup>	
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) <sup>4, 10</sup>	100% <sup>14</sup>	
<b>Mental Health</b> In-Patient Out-Patient (office visit)	\$500 Copay per day <sup>1</sup> – Days 1-5 \$40 Copay (ded waived)	100% <sup>1</sup> 100% <sup>1</sup>	
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	\$500 Copay per day <sup>1</sup> – Days 1-5	100% <sup>1</sup>	
<b>Infertility</b> 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	
<b>Pediatric Vision</b> 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 <sup>6</sup>	MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year <sup>6</sup>	
<b>Pediatric Dental</b> Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay	Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay	

† HSA Qualified High Deductible Plan

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

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

8. Copayments do not contribute to out-of-pocket maximum.

9. Maximum member responsibility.

10. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
11. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
12. Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.





# Gold PPO

Groups Beginning 10/1/17

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

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

(Foot notes continued on page 38)

# Gold PPO

Groups Beginning 10/1/17

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

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

(Foot notes continued on page 38)

# Silver HMO

Groups Beginning 10/1/17

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

Services	HMO A
Participating Health Plans	Anthem Blue Cross
Network Name	Select HMO
<b>Metal Tier</b>	<b>Silver</b>
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% <sup>13</sup>
Hospice	100%
Durable Medical Equipment (Covered when medically necessary)	50%
<b>Mental Health</b>	
In-Patient	60%
Out-Patient (office visit)	\$50 Copay (ded waived)
<b>Drug/Substance Abuse</b>	
In-Patient (Detox Only)	60%
<b>Infertility</b>	
Infertility Evaluation and Treatment	\$50 Copay (ded waived) <sup>6</sup>
Infertility Drugs	Not Covered
In Vitro Fertilization (IVF)	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered
<b>Pediatric Vision</b>	
Carrier	Anthem Vision
Network	Blue View Vision
Exam	100% (ded waived)
Contact Lenses	1 pair per calendar year
Frames	1 pair per calendar year (ded waived)
Maximum Allowance per year	1 per calendar year
<b>Pediatric Dental</b>	
Carrier	Anthem Dental
Network	Prime
Deductible	Combined Med/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical
Office Visit	100%
Diagnostic & Preventative (D&P)	100% (ded waived)
Basic Services	50%
Major Services (no waiting period)	50%
Orthodontics (medically necessary)	50%

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

- See plan specific EOC for information on preventive services.
- Family Deductible: For any given member, cost share applies either after he/she meets their individual deductible, or after the entire family deductible is met. The family deductible can be met by any combination of amounts from any member, but no one member is required to meet his/her individual deductible.
- Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.
- Limited to 100 4-hour visits per benefit period.
- Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
- Evaluation only.
- Maximum member responsibility.
- Medical emergency only.
- 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.
- In an office setting.
- Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
- Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
- Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
- Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.



# Silver HMO & HSP

Groups Beginning 10/1/17

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



# Silver HMO & HSP

## Groups Beginning 10/1/17

Services	HSP A	HMO B	HMO C
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
<b>Metal Tier</b>	<b>Silver</b>	<b>Silver</b>	<b>Silver</b>
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50% (no limit)	70%	80%
Hospice	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	70% (ded waived) <sup>8</sup>	80% (ded waived) <sup>8</sup>
<b>Mental Health</b> In-Patient Out-Patient (office visit)	50% \$30 Copay	70% \$45 Copay (ded waived)	80% \$50 Copay (ded waived)
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	50%	70%	80%
<b>Infertility</b> Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	50% <sup>9</sup> 50% <sup>9</sup> Not Covered 50% <sup>9</sup> Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
<b>Pediatric Vision</b> Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	EyeMed <sup>10</sup> EyeMed 100% 100% 1 pair per calendar year None	Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) None	Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) None
<b>Pediatric Dental</b> 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 <sup>10,11</sup> Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	Delta Dental DeltaCare USA None \$350 / \$700 100% (ded waived) 100% (ded waived) \$95 Copay <sup>2</sup> \$365 Copay <sup>3</sup> \$350 Copay	Delta Dental DeltaCare USA None \$350 / \$700 100% (ded waived) 100% (ded waived) \$95 Copay <sup>2</sup> \$365 Copay <sup>3</sup> \$350 Copay

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

- 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).
- 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.
- 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.
- 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.
- See plan specific EOC for information on preventive services.
- Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.

- Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
- 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.
- Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.
- Pediatric dental and vision are included on all plans.
- 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.
- Maximum member responsibility.





# Silver HMO

Groups Beginning 10/1/17

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

Services	HMO D <sup>†</sup>	HSA Qualified	HMO A	HMO B
Participating Health Plans	Kaiser Permanente		Sharp	Sharp
Network Name	Full		Premier	Performance
<b>Metal Tier</b>	<b>Silver</b>		<b>Silver</b>	<b>Silver</b>
Home Health Care (Max 100 visits per year)	100% <sup>10</sup>		\$30 Copay (ded waived)	\$35 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%		\$200 Copay per day	70%
Hospice	100%		100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	70%		50%	50%
<b>Mental Health</b>				
In-Patient	70%		\$750 Copay per day	70%
Out-Patient (office visit)	70%		\$30 Copay (ded waived)	\$35 Copay (ded waived)
<b>Drug/Substance Abuse</b>				
In-Patient (Detox Only)	70%		\$750 Copay per day	70%
<b>Infertility</b>				
Infertility Evaluation and Treatment	Not Covered		Not Covered	Not Covered
Infertility Drugs	Not Covered		Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered		Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered		Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered		Not Covered	Not Covered
<b>Pediatric Vision</b>				
Carrier	Kaiser Permanente		VSP	VSP
Network	Kaiser Permanente		VSP	VSP
Exam	100% (ded waived)		100%	100%
Contact Lenses	1 pair per calendar year		1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses
Frames	1 pair per calendar year (ded waived)		100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None		None	None
<b>Pediatric Dental</b>				
Carrier	Delta Dental		Premier Access	Premier Access
Network	DeltaCare USA		Access Dental DHMO	Access Dental DHMO
Deductible	None		None	None
Out-of-Pocket Maximum	\$350 / \$700		\$1,000 / \$2,000 <sup>3</sup>	\$1,000 / \$2,000 <sup>3</sup>
Office Visit	100% (ded waived)		\$20 Copay	\$20 Copay
Diagnostic & Preventative (D&P)	100% (ded waived)		100%	100%
Basic Services	\$95 Copay <sup>4</sup>		\$95 Copay <sup>4</sup>	\$95 Copay <sup>4</sup>
Major Services (no waiting period)	\$365 Copay <sup>5</sup>		\$365 Copay <sup>5</sup>	\$365 Copay <sup>5</sup>
Orthodontics (medically necessary)	\$350 Copay		\$1,000 Copay	\$1,000 Copay

<sup>†</sup> HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.

2. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.

3. The pediatric dental out-of-pocket maximum is \$1,000 for a family with one child and \$2,000 for a family with 2 or more children.

4. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.

5. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.

6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.

7. \$1,350 Self only enrollment, \$2,600 for any one member within a Family enrollment. \$2,700 for an entire Family. Does not apply to preventive care.

8. Under a family contract, an insured can satisfy their individual out-of-pocket maximum however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.

9. Maximum member responsibility.

10. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).



# Silver HMO

Groups Beginning 10/1/17

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

Services	HMO C	HMO B	HMO C <sup>†</sup>	HSA Qualified
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus	
Network Name	Premier	Full	Full	
<b>Metal Tier</b>	<b>Silver</b>	<b>Silver</b>	<b>Silver</b>	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50%	80%	80%	
Hospice	100% (ded waived)	100% (ded waived)	100%	
Durable Medical Equipment (Covered when medically necessary)	50%	80% (ded waived)	80%	
<b>Mental Health</b>				
In-Patient	50%	80% <sup>11</sup>	80% <sup>11</sup>	
Out-Patient (office visit)	\$40 Copay (ded waived)	\$45 Copay (ded waived) <sup>12</sup>	\$35 Copay <sup>12</sup>	
<b>Drug/Substance Abuse</b>				
In-Patient (Detox Only)	50%	80% <sup>11</sup>	80% <sup>11</sup>	
<b>Infertility</b>				
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered	
Infertility Drugs	Not Covered	Not Covered	Not Covered	
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	
<b>Pediatric Vision</b>				
Carrier	VSP	VSP	VSP	
Network	VSP	Choice Network	Choice Network	
Exam	100%	100% (ded waived) <sup>6</sup>	100% (ded waived) <sup>6</sup>	
Contact Lenses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses; ded waived) <sup>6,7</sup>	100% (in lieu of eyeglasses; ded waived) <sup>6,7</sup>	
Frames	100% (Pediatric Exchange collection only)	100% (ded waived) <sup>6,7</sup>	100% (ded waived) <sup>6,7</sup>	
Maximum Allowance per year	None	1 pair per year	1 pair per year	
<b>Pediatric Dental</b>				
Carrier	Premier Access	Delta Dental	Delta Dental	
Network	Access Dental DHMO	DeltaCare USA	DeltaCare USA	
Deductible	None	None	None	
Out-of-Pocket Maximum	\$1,000 / \$2,000 <sup>16</sup>	Combined with Medical	Combined with Medical	
Office Visit	\$20 Copay	Copay varies by service	Copay varies by service	
Diagnostic & Preventative (D&P)	100%	100% (ded waived)	100% (ded waived)	
Basic Services	\$95 Copay <sup>17</sup>	\$25 Copay (ded waived)	\$25 Copay (ded waived)	
Major Services (no waiting period)	\$365 Copay <sup>18</sup>	Copay varies by service (ded waived)	Copay varies by service (ded waived)	
Orthodontics (medically necessary)	\$1,000 Copay	\$1,000 Copay (ded waived)	\$1,000 Copay (ded waived)	

<sup>†</sup> HSA Qualified High Deductible Plan

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

1. Family Deductibles and Out-of-Pocket Maximum (OOPM) values are equal to two times the individual values. Except for HDHPs, an individual in a Family plan, is only responsible for the single Deductible amount and the single OOPM amount. Except for optional benefits, if elected, Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible and OOPM. Each individual Family Member is responsible for the amounts listed for any one Member in a Family of two or more Members until the Family as a whole meets the Family Deductible or OOPM. Once the Family as a whole meets the Family OOPM, the plan pays all costs for Covered Services for all Family Members. For HDHPs, in Family coverage, an individual Family Member's payment toward a Deductible, if required, must be the higher of the specified Deductible amount for individual (self only) coverage or \$2,600 for the 2016 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.

2. Cost sharing amounts for all essential health benefits, including those applied to deductible, accumulate toward the out-of-pocket maximum.

3. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.

4. Medications prescribed for sexual dysfunction are subject to prior authorization, have a 50% cost share, and some are limited to 8 doses per 30-day supply.

5. See plan specific EOC for information on preventive services.

6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.

7. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year;

Dailies: 1 month supply per year.

8. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.

9. Maximum member responsibility.

10. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.

11. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.

12. Mental/Behavioral Health/Substance Use Disorder (MH/SUD) other outpatient services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism. These and other MH/SUD services that fall between inpatient care and regular outpatient office visits may have a different cost share.

(Foot notes continued on page 38)



# Silver HMO

Groups Beginning 10/1/17

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Alliance
<b>Metal Tier</b>	<b>Silver</b>	<b>Silver</b>	<b>Silver</b>
Calendar Year Deductible*	\$2,000 / \$4,000 <sup>5</sup> (applies to Max OOP)	\$2,000 / \$4,000 <sup>5</sup> (applies to Max OOP)	\$2,000 / \$4,000 <sup>8</sup> (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,750 / \$13,500 <sup>6</sup>	\$6,750 / \$13,500 <sup>6</sup>	\$6,750 / \$13,500 <sup>9</sup>
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$45 Copay (ded waived)	\$45 Copay (ded waived)	70%
Specialist Visit (SPC)	\$65 Copay (ded waived)	\$65 Copay (ded waived)	70%
Laboratory	\$25 Copay (ded waived)	\$25 Copay (ded waived)	70%
X-Ray	\$25 Copay (ded waived)	\$25 Copay (ded waived)	70%
MRI, CT and PET (office setting)	\$200 Copay per procedure (ded waived)	\$200 Copay per procedure (ded waived)	70%
<b>Hospital Services – In-Patient</b>	60%	60%	70%
In-Patient Physician Fees	60% (ded waived)	60% (ded waived)	70% (ded waived)
Emergency Room (copay waived if admitted)	\$400 Copay (ded waived)	\$400 Copay (ded waived)	70%
Urgent Care	\$100 Copay (ded waived)	\$100 Copay (ded waived)	70%
<b>Hospital Services – Out-Patient</b>			
Surgical Facility	60%	60%	70%
Ambulatory Surgery Center	60%	60%	70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$65 Copay (ded waived)	\$65 Copay (ded waived)	70%
Ambulance Services (per trip)	\$100 Copay (ded waived)	\$100 Copay (ded waived)	70%
<b>Rx Benefits</b>			
Generic	\$20 Copay (ded waived)	\$20 Copay (ded waived)	\$20 Copay (ded waived)
Formulary Brand	\$200 / \$400 Ded – \$50 Copay <sup>2</sup>	\$200 / \$400 Ded – \$50 Copay <sup>2</sup>	\$200 / \$400 Ded – \$50 Copay <sup>2</sup>
Non-Formulary Brand	\$200 / \$400 Ded – \$100 Copay <sup>2</sup>	\$200 / \$400 Ded – \$100 Copay <sup>2</sup>	\$200 / \$400 Ded – \$100 Copay <sup>2</sup>
Specialty	\$200 / \$400 Ded – 75% (up to \$250 per prescription <sup>4</sup> ) <sup>2</sup>	\$200 / \$400 Ded – 75% (up to \$250 per prescription <sup>4</sup> ) <sup>2</sup>	\$200 / \$400 Ded – 75% (up to \$250 per prescription <sup>4</sup> ) <sup>2</sup>
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	\$200 / \$400 Ded – Applicable Rx Copay <sup>2</sup>	\$200 / \$400 Ded – Applicable Rx Copay <sup>2</sup>	\$200 / \$400 Ded – Applicable Rx Copay <sup>2</sup>
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) <sup>1</sup>	100% (ded waived) <sup>1</sup>	100% (ded waived) <sup>1</sup>
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	\$150 Copay (ded waived) <sup>7</sup>	\$150 Copay (ded waived) <sup>7</sup>	70%
Chiropractic (20 visits max per year)	\$15 Copay (ded waived)	\$15 Copay (ded waived)	70%
Acupuncture	\$10 Copay (ded waived)	\$10 Copay (ded waived)	70%
Physical, Occupational, Speech Therapy	\$45 Copay (ded waived)	\$45 Copay (ded waived)	70%
Rehabilitative & Habilitative Services and Devices	\$45 Copay (ded waived)	\$45 Copay (ded waived)	70%
Home Health Care (Max 100 visits per year)	\$45 Copay (ded waived)	\$45 Copay (ded waived)	70%

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Alliance
<b>Metal Tier</b>	<b>Silver</b>	<b>Silver</b>	<b>Silver</b>
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	70%
Hospice	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	\$50 Copay (ded waived)	\$50 Copay (ded waived)	70%
<b>Mental Health</b> In-Patient Out-Patient (office visit)	60% \$65 Copay (ded waived)	60% \$65 Copay (ded waived)	70% 70%
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	60%	60%	70%
<b>Infertility</b> Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) <sup>3</sup> Not Covered	50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) <sup>3</sup> Not Covered	50% See Plan Specific EOC Not Covered 50% <sup>3</sup> Not Covered
<b>Pediatric Vision</b> Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar year
<b>Pediatric Dental</b> Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service \$1,000 Copay	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service \$1,000 Copay	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service \$1,000 Copay

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

1. See plan specific EOC for information on preventive services.

2. For Specialty drugs, please see plan specific EOC.

3. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.

4. Maximum member responsibility.

5. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.

6. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.

7. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.

8. The Family Deductible is a non-embedded deductible. One or more eligible members of a family unit may satisfy the entire Family Deductible. No one in the family will be eligible for benefits until the Family Deductible has been satisfied.

9. When more than one person in a family is covered under the Health Plan, the Individual Out-of-Pocket Maximum does not apply. Copayments for Covered Services will continue to be required from every eligible member of the family until the Family Out-of-Pocket Maximum has been met. No further Copayments will be required for Covered Services (except infertility services) for the Calendar Year from any eligible family member once the Family Out-of-Pocket Maximum has been satisfied.



# Silver HMO

Groups Beginning 10/1/17

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



Services	HMO D	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
<b>Metal Tier</b>	<b>Silver</b>	<b>Silver</b>	<b>Silver</b>
Hospice	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	\$50 Copay (ded waived)	80% (ded waived) <sup>4,5</sup>	80% (ded waived) <sup>4,5</sup>
<b>Mental Health</b> In-Patient Out-Patient (office visit)	60% \$65 Copay (ded waived)	80% <sup>1,4</sup> \$50 Copay (ded waived)	80% <sup>1,4</sup> \$45 Copay (ded waived)
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	60%	80% <sup>1,4</sup>	80% <sup>1,4</sup>
<b>Infertility</b> Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) <sup>10</sup> Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
<b>Pediatric Vision</b> Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year <sup>7</sup>	MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year <sup>7</sup>
<b>Pediatric Dental</b> Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service \$1,000 Copay	Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay	Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay

† HSA Qualified High Deductible Plan

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

- 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.
- The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
- There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
- Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
- See copayment summary for applicable prosthetic/orthotic device copayment amount.
- See plan specific EOC for information on preventive services.
- Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
- Maximum member responsibility.
- For Specialty drugs, please see plan specific EOC.
- Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
- 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.

- 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.
- In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
- 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.
- Copayments do not contribute to out-of-pocket maximum.
- Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.





# Silver HMO

Groups Beginning 10/1/17

Services	HMO C <sup>†</sup>	HSA Qualified
Participating Health Plans	Western Health Advantage	
Network Name	Full	
<b>Metal Tier</b>	<b>Silver</b>	
Calendar Year Deductible*	\$2,000 / \$2,600 / \$4,000 <sup>1,9,10</sup> (combined Med/Rx ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$6,550 / \$13,100 <sup>2,10</sup>	
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	80% <sup>1,4</sup>	
Specialist Visit (SPC)	80% <sup>1,4</sup>	
Laboratory	80% <sup>1,4</sup>	
X-Ray	80% <sup>1,4</sup>	
MRI, CT and PET (office setting)	80% <sup>1,4</sup>	
<b>Hospital Services – In-Patient</b>	80% <sup>1,4</sup>	
In-Patient Physician Fees	80% <sup>1,4</sup>	
Emergency Room (copay waived if admitted)	80% <sup>1,4</sup>	
Urgent Care	80% <sup>1,4</sup>	
<b>Hospital Services – Out-Patient</b>		
Surgical Facility	80% <sup>1,4</sup>	
Ambulatory Surgery Center	80% <sup>1,4</sup>	
Hospital Pre-Authorization	Required	
2nd Surgical Opinion	80% <sup>1,4</sup>	
Ambulance Services (per trip)	80% <sup>1,4</sup>	
<b>Rx Benefits</b>		
Generic	80% (up to \$250 per 30 day supply <sup>8</sup> ) (combined Med/Rx ded) <sup>1,4</sup>	
Formulary Brand	80% (up to \$250 per 30 day supply <sup>8</sup> ) (combined Med/Rx ded) <sup>1,4,11</sup>	
Non-Formulary Brand	80% (up to \$250 per 30 day supply <sup>8</sup> ) (combined Med/Rx ded) <sup>1,4,11</sup>	
Specialty	80% (up to \$250 per 30 day supply <sup>8</sup> ) (combined Med/Rx ded) <sup>1,4</sup>	
Oral Contraceptives	100% (ded waived)	
Diabetes – Self-Injectable	80% (up to \$250 per 30 day supply <sup>8</sup> ) (combined Med/Rx ded) <sup>1,4</sup>	
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) <sup>3,6</sup>	
Chronic Disease Management	Covered as any Illness	
Chemotherapy	80% <sup>1,4</sup>	
Chiropractic (20 visits max per year)	Not Covered	
Acupuncture	80% <sup>1,4</sup>	
Physical, Occupational, Speech Therapy	80% <sup>1,4</sup>	
Rehabilitative & Habilitative Services and Devices	80% <sup>1,4</sup>	

Services	HMO C†	HSA Qualified
Participating Health Plans	Western Health Advantage	
Network Name	Full	
<b>Metal Tier</b>	<b>Silver</b>	
Home Health Care (Max 100 visits per year)	80% <sup>1,4</sup>	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% <sup>1,4</sup>	
Hospice	100% <sup>1</sup>	
Durable Medical Equipment (Covered when medically necessary)	80% <sup>1,4,5</sup>	
<b>Mental Health</b> In-Patient Out-Patient (office visit)	80% <sup>1,4</sup> 80% <sup>1,4</sup>	
<b>Drug/Substance Abuse</b> In-Patient (Detox Only)	80% <sup>1,4</sup>	
<b>Infertility</b> 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	
<b>Pediatric Vision</b> 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 <sup>7</sup>	
<b>Pediatric Dental</b> Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay	

† HSA Qualified High Deductible Plan

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

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



# Silver PPO

Groups Beginning 10/1/17

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

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
<b>Metal Tier</b>	<b>Silver</b>		<b>Silver</b>	
	In-Network	Out-of-Network <sup>10</sup>	In-Network	Out-of-Network <sup>10</sup>
Rehabilitative & Habilitative Services and Devices	60% <sup>12</sup>	50% <sup>12</sup>	70% <sup>12</sup>	50% <sup>12</sup>
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) <sup>4</sup>	50% (up to \$75 per visit) (Max 100 visits per benefit period) <sup>4, 5</sup>	70% (Max 100 visits per benefit period) <sup>4</sup>	50% (up to \$75 per visit) (Max 100 visits per benefit period) <sup>4, 5</sup>
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 60% <sup>13</sup> Tier 2: \$500 Copay per admit – 60% <sup>13</sup>	50% (up to \$150 per day) <sup>5, 13</sup>	\$750 Copay per admit <sup>13</sup>	50% (up to \$150 per day) <sup>5, 13</sup>
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%	50%
<b>Mental Health</b>				
In-Patient	Tier 1: 60% Tier 2: \$500 Copay per admit – 60%	50% (up to \$650 per day) <sup>5</sup>	\$750 Copay per admit	50% (up to \$650 per day) <sup>5</sup>
Out-Patient (office visit)	\$25 Copay (first 3 visits) <sup>9</sup> – 60%	50%	\$35 Copay (first 3 visits) <sup>9</sup> – 70%	50%
<b>Drug/Substance Abuse</b>				
In-Patient (Detox Only)	Tier 1: 60% Tier 2: \$500 Copay per admit – 60%	50% (up to \$650 per day) <sup>5</sup>	\$750 Copay per admit	50% (up to \$650 per day) <sup>5</sup>
<b>Infertility</b>				
Infertility Evaluation and Treatment	\$25 Copay (first 3 visits) <sup>9</sup> – 60% <sup>7</sup>	50% <sup>7</sup>	\$35 Copay (first 3 visits) <sup>9</sup> – 70% <sup>7</sup>	50% <sup>7</sup>
Infertility Drugs	Not Covered	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	Not Covered
<b>Pediatric Vision</b>				
Carrier Network Exam	Anthem Vision Blue View Vision 100% (ded waived)	Anthem Vision	Anthem Vision Blue View Vision 100% (ded waived)	Anthem Vision
Contact Lenses	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Frames	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)
Maximum Allowance per year	1 per calendar year	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year)	1 per calendar year	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year)
<b>Pediatric Dental</b>				
Carrier Network Deductible	Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON)	Anthem Dental	Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON)	Anthem Dental
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	50%	50%	50%	50%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

(Foot notes continued on page 39)

# Silver EPO

Groups Beginning 10/1/17

Services	EPO A	EPO B †	HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	Prudent Buyer – Small Group	
<b>Metal Tier</b>	<b>Silver</b>	<b>Silver</b>	
Calendar Year Deductible*	\$2,000 / \$4,000 <sup>2</sup> (combined Med/Pediatric dental ded)(applies to Max OOP)	\$2,000 / \$2,600 / \$4,000 <sup>10</sup> (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$7,150 / \$14,300 <sup>3</sup>	\$5,750 / \$11,500 <sup>3</sup>	
Lifetime Maximum	Unlimited	Unlimited	
Dr. Office Visits (PCP)	\$50 Copay (first 3 visits) <sup>8</sup> – 70%	80%	
Specialist Visit (SPC)	\$50 Copay (first 3 visits) <sup>8</sup> – 70%	80%	
Laboratory	70%	80%	
X-Ray	70%	80%	
MRI, CT and PET (office setting)	70% <sup>15</sup>	80% <sup>15</sup>	
<b>Hospital Services – In-Patient</b>	\$750 Copay per admit	80%	
In-Patient Physician Fees	70%	80%	
Emergency Room (copay waived if admitted)	\$300 Copay – 70%	80%	
Urgent Care	70%	80%	
<b>Hospital Services – Out-Patient</b>			
Surgical Facility	\$300 Copay per admit – 70%	80%	
Ambulatory Surgery Center	\$300 Copay per admit – 70%	80%	
Hospital Pre-Authorization	Required	Required	
2nd Surgical Opinion	\$50 Copay (first 3 visits) <sup>9</sup> – 70%	80%	
Ambulance Services (per trip)	70% <sup>9</sup>	80% <sup>9</sup>	
<b>Rx Benefits</b>			
Generic	\$5 Copay / \$20 Copay (overall ded waived) <sup>11</sup>	80% (up to \$250 per prescription <sup>7</sup> ) (combined Med/Rx/Pediatric dental ded) <sup>11</sup>	
Formulary Brand	\$40 Copay (overall ded waived) <sup>11</sup>	80% (up to \$250 per prescription <sup>7</sup> ) (combined Med/Rx/Pediatric dental ded) <sup>11</sup>	
Non-Formulary Brand	\$80 Copay (overall ded waived) <sup>11</sup>	80% (up to \$250 per prescription <sup>7</sup> ) (combined Med/Rx/Pediatric dental ded) <sup>11</sup>	
Specialty	70% (up to \$250 per prescription <sup>7</sup> ) (overall ded waived) (prior auth. required) <sup>5,11</sup>	80% (up to \$250 per prescription <sup>7</sup> ) (combined Med/Rx/Pediatric dental ded) (prior auth. required) <sup>5,11</sup>	
Oral Contraceptives	100%	100%	
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) <sup>11</sup>	80% (up to \$250 per prescription <sup>7</sup> ) (combined Med/Rx/Pediatric dental ded) <sup>11</sup>	
Pre-Existing Conditions	Covered	Covered	
Maternity and Newborn Care	Covered as any illness	Covered as any illness	
Preventive/Wellness Services	100% (ded waived) <sup>1</sup>	100% (ded waived) <sup>1</sup>	
Chronic Disease Management	Covered as any illness	Covered as any illness	
Chemotherapy	70%	80%	
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) <sup>12</sup>	50% (20 visits max per benefit period) <sup>12</sup>	
Acupuncture	70%	80%	
Physical, Occupational, Speech Therapy	70%	80%	

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

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.

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

3. Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.

4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.

5. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.

6. Evaluation only.

7. Maximum member responsibility.

8. Office visits are per Member and combined for primary care physician, specialist, other provider, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional), Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are

received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.

9. Medical emergency only.

10. Deductible applies depending on who is covered under the plan at the time service is rendered - Subscriber only: \$2,000 individual deductible; or Subscriber and Family coverage: \$2,600 individual and \$4,000 family deductible. For family deductible, for any given member, cost share applies either after he/she meets the per member deductible, or after the entire per family deductible is met. The per family deductible can be met by any combination of amounts from any member, but no one member is required to meet his/her per member deductible.

11. The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.

12. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.

13. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

14. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).

15. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.





# Additional Footnotes

## Gold HMO

(Foot notes continued from page 9)

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

## Gold PPO

(Foot notes continued from page 17)

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

## Gold PPO

(Foot notes continued from page 19)

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

## Silver HMO

(Foot notes continued from page 27)

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

## Silver PPO

(Foot notes continued from page 35)

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





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