

Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 10/1/17

Platinum



Platinum HMO.....2

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.

Platinum HMO

Groups Beginning 10/1/17

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

Platinum HMO

Groups Beginning 10/1/17

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

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

- Must be medically necessary.
- Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.
- Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
- See plan specific EOC for information on preventive services.
- Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
- The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
- See plan specific EOC for information regarding preventive drugs and women's contraceptives.
- 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.
- Family out-of-pocket limit: For any given member, the out-of-pocket limit is met either after he/she meets their individual out-of-pocket limit, or after the entire family out-of-pocket limit is met. The family out-of-pocket limit can be met by any combination of amounts from any Member, but no one Member is required to meet his/her individual out-of-pocket limit.

10. Pediatric dental and vision are included on all plans.

- 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.
- 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.



Platinum HMO

Groups Beginning 10/1/17

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

Services	HMO A	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	Platinum	Platinum	Platinum
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$150 Copay per day – 5 days max	\$200 Copay	85%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	90% ⁶	50%	50%
Mental Health In-Patient Out-Patient (office visit)	\$300 Copay per day – 5 days max \$10 Copay	\$400 Copay \$15 Copay	85% \$15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	\$300 Copay per day – 5 days max	\$400 Copay	85%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	Kaiser Permanente Kaiser Permanente 100% 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	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Delta Dental DeltaCare USA None \$350 / \$700 100% 100% \$40 Copay ² \$365 Copay ³ \$350 Copay	Premier Access Access Dental DHMO None \$1,000 / \$2,000 ⁷ \$20 Copay 100% \$95 Copay ² \$365 Copay ³ \$1,000 Copay	Premier Access Access Dental DHMO None \$1,000 / \$2,000 ⁷ \$20 Copay 100% \$95 Copay ² \$365 Copay ³ \$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.
- 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.



Platinum HMO

Groups Beginning 10/1/17

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

Platinum HMO

Groups Beginning 10/1/17

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	Platinum	Platinum	Platinum
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$200 Copay	\$150 Copay per day – 5 days max	90%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	90%	90%
Mental Health In-Patient Out-Patient (office visit)	\$350 Copay per day – 5 days max \$10 Copay	\$250 Copay per day – 5 days max ⁹ \$15 Copay ¹⁰	\$250 Copay per day – 5 days max ⁹ \$25 Copay ¹⁰
Drug/Substance Abuse In-Patient (Detox Only)	\$350 Copay per day – 5 days max	\$250 Copay per day – 5 days max ⁹	\$250 Copay per day – 5 days max ⁹
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	VSP Choice Network 100% ⁵ 100% (in lieu of eyeglasses) ^{5,6} 100% ^{5,6} 1 pair per year	VSP Choice Network 100% ⁵ 100% (in lieu of eyeglasses) ^{5,6} 100% ^{5,6} 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Premier Access Access Dental DHMO None \$1,000/\$2,000 ¹³ \$20 Copay 100% \$95 Copay ¹⁴ \$365 Copay ¹⁵ \$1,000 Copay	Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% \$25 Copay Copay varies by service \$1,000 Copay	Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% \$25 Copay Copay varies by service \$1,000 Copay

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

- 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.
- See plan specific EOC for information on preventive services.
- 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.
- 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.
- Maximum member responsibility.

- 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.
- Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
- Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
- 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.
- 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.



Platinum HMO

Groups Beginning 10/1/17

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

Platinum HMO

Groups Beginning 10/1/17

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

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

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

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

4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
6. Maximum member responsibility.



Platinum HMO

Groups Beginning 10/1/17

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

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

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

1. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
2. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
3. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
4. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. Maximum member responsibility.

7. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.

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



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