

Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4/1/18

Platinum/Gold



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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.

Platinum HMO

Groups Beginning 4/1/18

Services	HMO A	HMO A	HMO B
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	Salud HMO y Mas	WholeCare
Metal Tier	Platinum	Platinum	Platinum
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	\$2,000 / \$4,000 ⁹	\$2,000 / \$4,000 ³	\$2,000 / \$4,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$10 Copay	\$20 Copay	\$20 Copay
Specialist Visit (SPC)	\$20 Copay	\$20 Copay	\$20 Copay
Laboratory	\$10 Copay ¹⁸	\$20 Copay	\$20 Copay
X-Ray	\$10 Copay ¹⁸	\$20 Copay	\$20 Copay
MRI, CT and PET (office setting)	\$150 Copay per test ²⁰	\$20 Copay per procedure	\$20 Copay per procedure
Hospital Services – In-Patient	\$200 Copay per day – 3 days max per admit	\$350 Copay	\$350 Copay
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	\$100 Copay	\$100 Copay	\$100 Copay
Urgent Care	\$10 Copay	\$20 Copay	\$20 Copay
Hospital Services – Out-Patient			
Surgical Facility	\$150 Copay	\$350 Copay	\$350 Copay
Ambulatory Surgery Center	\$150 Copay	\$350 Copay ²¹	\$350 Copay ²¹
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$20 Copay	\$20 Copay	\$20 Copay
Ambulance Services (per trip)	90% ¹⁵	\$50 Copay	\$50 Copay
Rx Benefits			
Generic	\$5 Copay / \$15 Copay ¹⁶	\$5 Copay ^{6,7}	\$5 Copay ^{6,7}
Formulary Brand	\$35 Copay ¹⁶	\$20 Copay ^{6,7}	\$20 Copay ^{6,7}
Non-Formulary Brand	\$70 Copay ¹⁶	\$50 Copay ^{6,7}	\$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}	70% (up to \$250 per prescription ¹⁴) (prior auth. required) ^{6,7}
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay ¹⁶	Applicable Rx Copay ^{6,7}	Applicable Rx Copay ^{6,7}
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any illness	Covered as any illness	Covered as any illness
Preventive/Wellness Services	100% ⁴	100% ⁴	100% ⁴
Chronic Disease Management	Covered as any illness	\$20 Copay	\$20 Copay
Chemotherapy	\$20 Copay	100%	100%
Chiropractic (20 visits max per year)	\$10 Copay (20 visits max per benefit period) ¹⁷	Not Covered	Not Covered
Acupuncture	\$10 Copay	\$20 Copay ¹	\$20 Copay
Physical, Occupational, Speech Therapy	\$10 Copay ¹⁸	\$20 Copay	\$20 Copay
Rehabilitative & Habilitative Services and Devices	\$10 Copay ¹⁸	\$20 Copay	\$20 Copay
Home Health Care (Max 100 visits per year)	\$10 Copay (Max 100 visits per benefit period) ¹¹	100%	100%

Platinum HMO

Groups Beginning 4/1/18

Services	HMO A	HMO A	HMO B
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	Salud HMO y Mas	WholeCare
Metal Tier	Platinum	Platinum	Platinum
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100% ¹⁹	\$350 Copay (no limit)	\$350 Copay (no limit)
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	70%	70%
Mental Health			
In-Patient	\$200 Copay per day – 3 days max per admit	\$350 Copay ⁵	\$350 Copay ⁵
Out-Patient (office visit)	\$10 Copay	\$20 Copay ⁵	\$20 Copay ⁵
Drug/Substance Abuse			
In-Patient (Detox Only)	\$200 Copay per day – 3 days max per admit	\$350 Copay	\$350 Copay
Infertility			
Infertility Evaluation and Treatment	\$10 Copay ¹³	50% ²	50% ²
Infertility Drugs	Not Covered	50% ²	50% ²
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	50% ²	50% ²
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	EyeMed ¹⁰	EyeMed ¹⁰
Network	Blue View Vision	EyeMed	EyeMed
Exam	100%	100%	100%
Contact Lenses	100% (in lieu of eyeglasses)	100%	100%
Frames	100%	1 pair per calendar year	1 pair per calendar year
Maximum Allowance per year	1 per calendar year	None	None
Pediatric Dental			
Carrier	Anthem Dental	Dental Benefit Providers ^{8,10}	Dental Benefit Providers ^{8,10}
Network	Prime	Dental Benefit Providers	Dental Benefit Providers
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	50%	Copay varies by service	Copay varies by service
Major Services (no waiting period)	50%	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	50%	Copay varies by service	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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.

- 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.
- Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.



Platinum HMO

Groups Beginning 4/1/18

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Premier
Metal Tier	Platinum	Platinum	Platinum
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	\$3,000 / \$6,000	\$3,350 / \$6,700	\$3,500 / \$7,000 ⁴
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$10 Copay	\$15 Copay	\$15 Copay
Specialist Visit (SPC)	\$20 Copay	\$30 Copay	\$20 Copay
Laboratory	\$20 Copay	\$15 Copay	100%
X-Ray	\$40 Copay	\$30 Copay	100%
MRI, CT and PET (office setting)	\$150 Copay per procedure	\$75 Copay per procedure	\$150 Copay per procedure
Hospital Services – In-Patient	\$500 Copay per admit	\$250 Copay per day – 5 days max	\$400 Copay
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	\$200 Copay	\$150 Copay	\$150 Copay
Urgent Care	\$10 Copay	\$15 Copay	\$20 Copay
Hospital Services – Out-Patient			
Surgical Facility	\$300 Copay per procedure	\$125 Copay per procedure	80%
Ambulatory Surgery Center	\$300 Copay per procedure	\$125 Copay per procedure	80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$10 Copay	\$30 Copay	\$20 Copay
Ambulance Services (per trip)	\$150 Copay	\$150 Copay	\$150 Copay
Rx Benefits			
Generic	\$5 Copay	\$5 Copay	\$10 Copay
Formulary Brand	\$15 Copay	\$15 Copay	\$25 Copay
Non-Formulary Brand	\$15 Copay (with physician approval)	\$15 Copay (with physician approval)	\$50 Copay
Specialty	90% (up to \$250 per prescription ⁹) (with physician approval)	90% (up to \$250 per prescription ⁹) (with physician approval)	Applicable Rx Copay
Oral Contraceptives	100%	100%	100% (if in formulary)
Diabetes – Self-Injectable	\$15 Copay	\$15 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	\$30 Copay	\$20 Copay
Chemotherapy	100%	90%	Variable ⁸
Chiropractic (20 visits max per year)	\$15 Copay ¹⁰	Not Covered	Not Covered
Acupuncture	\$10 Copay ¹⁰	\$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	\$20 Copay	\$15 Copay

Platinum HMO

Groups Beginning 4/1/18

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Premier
Metal Tier	Platinum	Platinum	Platinum
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$250 Copay per admit	\$150 Copay per day – 5 days max	\$200 Copay
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	90% ⁶	90%	50%
Mental Health In-Patient Out-Patient (office visit)	\$500 Copay per admit \$10 Copay	\$250 Copay per day – 5 days max \$15 Copay	\$400 Copay \$15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	\$500 Copay per admit	\$250 Copay per day – 5 days max	\$400 Copay
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year ¹¹ 1 pair per calendar year ¹¹ None	Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year ¹¹ 1 pair per calendar year ¹¹ 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	Delta Dental DeltaCare USA None \$350 / \$700 100% 100% \$40 Copay ² \$365 Copay ³ \$350 Copay	Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ⁷ 100% 100% \$25 Copay ² \$350 Copay ³ \$350 Copay

* 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 \$350 for a family with one child and \$700 for a family with 2 or more children.
- Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
- Maximum member responsibility.
- 20 visits max per year combined for Chiropractic and Acupuncture.
- 1 pair of glasses or 1 pair of contact lenses per accumulation period.

Platinum HMO

Groups Beginning 4/1/18

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

Services	HMO B
Participating Health Plans	Sharp
Network Name	Performance
Metal Tier	Platinum
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	85%
Hospice	100%
Durable Medical Equipment (Covered when medically necessary)	50%
Mental Health In-Patient Out-Patient (office visit)	85% \$15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	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
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
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ⁵ 100% 100% \$25 Copay ¹ \$350 Copay ² \$350 Copay

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

1. 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.
2. 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.
3. 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.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental out-of-pocket maximum is \$350 for a family with one child and \$700 for a family with 2 or more children.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.



Platinum HMO

Groups Beginning 4/1/18

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	\$3,350 / \$6,700 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	\$30 Copay	\$25 Copay
Laboratory	\$20 Copay	\$15 Copay	\$25 Copay
X-Ray	\$40 Copay	\$30 Copay per procedure	\$25 Copay per procedure
MRI, CT and PET (office setting)	\$150 Copay per procedure	\$75 Copay per procedure	\$150 Copay per procedure
Hospital Services – In-Patient	\$350 Copay per day – 5 days max	\$250 Copay per day – 5 days max per admit	\$250 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	100%	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%	\$100 Copay	90%
Ambulatory Surgery Center	80%	\$100 Copay	90%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$20 Copay	\$30 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	Applicable Rx Copay ²
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
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$200 Copay	\$150 Copay per day – 5 days max per admit	90%

Platinum HMO

Groups Beginning 4/1/18

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
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	90%	90%
Mental Health			
In-Patient	\$350 Copay per day – 5 days max	\$250 Copay per day – 5 days max per admit ⁹	\$250 Copay per day – 5 days max per admit ⁹
Out-Patient (office visit)	\$10 Copay	\$15 Copay ¹⁰	\$25 Copay ¹⁰
Drug/Substance Abuse			
In-Patient (Detox Only)	\$350 Copay per day – 5 days max	\$250 Copay per day – 5 days max per admit ⁹	\$250 Copay per day – 5 days max per admit ⁹
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	VSP	VSP
Network	VSP	Choice Network	Choice Network
Exam	100%	100% ⁵	100% ⁵
Contact Lenses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses) ^{5, 6}	100% (in lieu of eyeglasses) ^{5, 6}
Frames	100% (Pediatric Exchange collection only)	100% ^{5, 6}	100% ^{5, 6}
Maximum Allowance per year	None	1 pair per year	1 pair per year
Pediatric Dental			
Carrier	Access Dental	Delta Dental	Delta Dental
Network	Access Dental Plan Children's Dental HMO	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	\$350 / \$700 ¹³	Combined with Medical	Combined with Medical
Office Visit	100%	Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	\$25 Copay ¹⁴	Copay varies by service	Copay varies by service
Major Services (no waiting period)	\$350 Copay ¹⁵	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	\$350 Copay	\$1,000 Copay	\$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 is met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day Copay price, through the mail-order form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
- 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 through the end of the month in which the member turns 19 years of age as part of the essential health benefit for pediatric vision.
- 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 \$350 for a family with one child and \$700 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 4/1/18

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	\$2,500 / \$5,000 ²	\$2,500 / \$5,000 ²	\$2,500 / \$5,000 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)	70%	70%	70%
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 ⁵) ³	75% (up to \$250 per prescription ⁵) ³	75% (up to \$250 per prescription ⁵) 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 4/1/18

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% \$20 Copay	70% \$20 Copay	70% \$20 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)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	UnitedHealthcare Vision 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. Maximum member responsibility.



Platinum HMO

Groups Beginning 4/1/18

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	\$3,350 / \$6,700 ¹
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$25 Copay	\$15 Copay
Specialist Visit (SPC)	\$25 Copay	\$30 Copay
Laboratory	100%	\$15 Copay
X-Ray	100%	\$30 Copay
MRI, CT and PET (office setting)	\$100 Copay	\$75 Copay
Hospital Services – In-Patient	\$250 Copay per day – Days 1-5	\$250 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	\$150 Copay	\$150 Copay
Urgent Care	\$50 Copay	\$15 Copay
Hospital Services – Out-Patient		
Surgical Facility	\$100 Copay	\$100 Copay
Ambulatory Surgery Center	\$100 Copay	\$100 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.



Gold HMO

Groups Beginning 4/1/18

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

Services	HMO A
Participating Health Plans	Anthem Blue Cross
Network Name	Select HMO
Metal Tier	Gold
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100% ¹¹
Hospice	100%
Durable Medical Equipment (Covered when medically necessary)	50%
Mental Health	
In-Patient	\$500 Copay per day – 3 days max per admit
Out-Patient (office visit)	\$25 Copay
Drug/Substance Abuse	
In-Patient (Detox Only)	\$500 Copay per day – 3 days max per admit
Infertility	
Infertility Evaluation and Treatment	\$25 Copay ⁹
Infertility Drugs	Not Covered
In Vitro Fertilization (IVF)	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered
Pediatric Vision	
Carrier	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
Pediatric Dental	
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; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
5. Limited to 100 4-hour visits per benefit period.
6. Manipulation Therapy only: benefit maximum of 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 4/1/18

Services	HMO A	HMO B	HSP A
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	PureCare
Metal Tier	Gold	Gold	Gold
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	\$45 Copay	\$5 Copay ¹⁰
Specialist Visit (SPC)	\$45 Copay	\$60 Copay	\$15 Copay ¹⁰
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
Hospital Services – In-Patient	\$650 Copay	\$800 Copay	60%
In-Patient Physician Fees	100%	100%	60%
Emergency Room (copay waived if admitted)	\$250 Copay	\$300 Copay	60%
Urgent Care	\$45 Copay	\$60 Copay	\$15 Copay
Hospital Services – Out-Patient			
Surgical Facility	60%	60%	60%
Ambulatory Surgery Center	60% ¹²	60% ¹²	60% ¹²
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$45 Copay	\$60 Copay	\$15 Copay
Ambulance Services (per trip)	\$250 Copay	\$300 Copay	60%
Rx Benefits			
Generic	\$10 Copay ^{5,7}	\$10 Copay ^{5,7}	\$5 Copay (overall ded waived)
Formulary Brand	\$50 Copay ^{5,6,7}	\$50 Copay ^{5,6,7}	\$20 Copay (overall ded waived)
Non-Formulary Brand	\$60 Copay ^{5,6,7}	\$60 Copay ^{5,6,7}	60% (up to \$250 per prescription ¹¹) (overall ded waived)
Specialty	60% (up to \$250 per prescription ¹¹) (prior auth. required) ^{5,6,7}	60% (up to \$250 per prescription ¹¹) (prior auth. required) ^{5,6,7}	60% (up to \$250 per prescription ¹¹) (overall ded waived)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay ^{5,6,7}	Applicable Rx Copay ^{5,6,7}	60% (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% ³	100% ³	100% (ded waived) ³
Chronic Disease Management	\$45 Copay	\$60 Copay	\$15 Copay
Chemotherapy	100%	100%	60%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	\$10 Copay ¹	\$10 Copay ¹	\$5 Copay
Physical, Occupational, Speech Therapy	\$30 Copay	\$45 Copay	\$5 Copay
Rehabilitative & Habilitative Services and Devices	\$30 Copay	\$45 Copay	\$5 Copay
Home Health Care (Max 100 visits per year)	\$30 Copay	\$45 Copay	60%

Gold HMO & HSP

Groups Beginning 4/1/18

Services	HMO A	HMO B	HSP A
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	PureCare
Metal Tier	Gold	Gold	Gold
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$25 Copay per day (no limit)	\$25 Copay per day (no limit)	60% (no limit)
Hospice	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%	60%	60%
Mental Health In-Patient Out-Patient (office visit)	\$650 Copay ⁴ \$30 Copay ⁴	\$800 Copay ⁴ \$45 Copay ⁴	60% \$5 Copay
Drug/Substance Abuse In-Patient (Detox Only)	\$650 Copay	\$800 Copay	60%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	50% ² 50% ² Not Covered 50% ² Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	50% ² 50% ² Not Covered 50% ² Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	EyeMed ⁹ EyeMed 100% 100% 1 pair per calendar year None	EyeMed ⁹ EyeMed 100% 100% 1 pair per calendar year None	EyeMed ⁹ EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Dental Benefit Providers ^{8,9} Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	Dental Benefit Providers ^{8,9} Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	Dental Benefit Providers ^{8,9} 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.
12. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.



Gold HMO

Groups Beginning 4/1/18

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Performance
Metal Tier	Gold	Gold	Gold
Calendar Year Deductible*	\$500 / \$1,000 ⁶ (applies to Max OOP)	None	None
Out-of-Pocket Max Ind/Fam	\$7,000 / \$14,000 ⁷	\$6,000 / \$12,000	\$6,500 / \$13,000 ⁴
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$30 Copay (ded waived)	\$25 Copay	\$20 Copay
Specialist Visit (SPC)	\$35 Copay (ded waived)	\$55 Copay	\$50 Copay
Laboratory	\$20 Copay (ded waived)	\$35 Copay	\$10 Copay
X-Ray	\$40 Copay (ded waived)	\$55 Copay	\$10 Copay
MRI, CT and PET (office setting)	\$300 Copay per procedure	\$275 Copay per procedure	\$175 Copay per procedure
Hospital Services – In-Patient	\$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	\$325 Copay	70%
Urgent Care	\$30 Copay (ded waived)	\$25 Copay	\$50 Copay
Hospital Services – Out-Patient			
Surgical Facility	\$600 Copay per procedure	\$340 Copay per procedure	70%
Ambulatory Surgery Center	\$600 Copay per procedure	\$340 Copay per procedure	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%
Rx Benefits			
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 ¹¹) (overall ded waived) (with physician approval)	80% (up to \$250 per prescription ¹¹) (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) ⁵	100% ⁵	100% ⁵
Chronic Disease Management	\$25 Copay	\$50 Copay	\$50 Copay
Chemotherapy	100% (ded waived)	80%	Variable ¹⁰
Chiropractic (20 visits max per year)	\$15 Copay (ded waived) ¹²	Not Covered	Not Covered
Acupuncture	\$30 Copay (ded waived) ¹²	\$25 Copay	\$20 Copay
Physical, Occupational, Speech Therapy	\$30 Copay (ded waived)	\$25 Copay	\$20 Copay
Rehabilitative & Habilitative Services and Devices	\$30 Copay (ded waived)	\$25 Copay	\$20 Copay
Home Health Care (Max 100 visits per year)	100% (ded waived) ¹	\$30 Copay ¹	\$20 Copay

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Performance
Metal Tier	Gold	Gold	Gold
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) ⁸	80% ⁸	50%
Mental Health In-Patient Out-Patient (office visit)	\$600 Copay per day – 5 days max \$30 Copay (ded waived)	\$600 Copay per day – 5 days max \$25 Copay	70% \$20 Copay
Drug/Substance Abuse In-Patient (Detox Only)	\$600 Copay per day – 5 days max	\$600 Copay per day – 5 days max	70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year ¹³ 1 pair per calendar year (ded waived) ¹³ None	Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year ¹³ 1 pair per calendar year ¹³ None	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Delta Dental DeltaCare USA None \$350 / \$700 100% (ded waived) 100% (ded waived) \$40 Copay ² \$365 Copay ³ \$350 Copay	Delta Dental DeltaCare USA None \$350 / \$700 100% 100% \$40 Copay ² \$365 Copay ³ \$350 Copay	Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ⁹ 100% 100% \$25 Copay ² \$350 Copay ³ \$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.
- 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 \$350 for a family with one child and \$700 for a family with 2 or more children.
- Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
- Maximum member responsibility.
- 20 visits max per year combined for Chiropractic and Acupuncture.
- 1 pair of glasses or 1 pair of contact lenses per accumulation period.



Gold HMO

Groups Beginning 4/1/18

Services	HMO B	HMO C	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Premier	Premier	Full
Metal Tier	Gold	Gold	Gold
Calendar Year Deductible*	None	\$500 / \$1,000 ¹⁷ (applies to Max OOP)	\$1,500 / \$3,000 ⁷ (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,850 / \$13,700 ³	\$6,850 / \$13,700 ^{17,18}	\$2,500 / \$5,000 ⁸
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$25 Copay	\$10 Copay (ded waived)	\$30 Copay ¹³
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 per procedure
MRI, CT and PET (office setting)	\$175 Copay per procedure	\$250 Copay per procedure	\$50 Copay per procedure
Hospital Services – In-Patient	\$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
Hospital Services – Out-Patient			
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
Rx Benefits			
Generic	\$19 Copay (ded waived)	\$10 Copay (overall ded waived)	\$5 Copay (overall ded waived) ⁹
Formulary Brand	\$150 / \$300 Ded – \$35 Copay	\$40 Copay (overall ded waived)	\$15 Copay (overall ded waived) ^{9,10}
Non-Formulary Brand	\$150 / \$300 Ded – \$70 Copay	\$70 Copay (overall ded waived)	\$25 Copay (overall ded waived) ^{9,10}
Specialty	\$150 / \$300 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)	80% (up to \$250 per prescription ¹⁴) (overall ded waived) ^{9,10}
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) ⁹
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% ⁴	100% (ded waived) ⁴	100% (ded waived) ⁴
Chronic Disease Management	\$60 Copay	\$20 Copay (ded waived)	Covered as any Illness
Chemotherapy	Variable ⁶	Variable ⁶	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
Metal Tier	Gold	Gold	Gold
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%
Mental Health In-Patient Out-Patient (office visit)	\$600 Copay per day – 5 days max \$25 Copay	50% \$10 Copay (ded waived)	80% ¹⁵ \$30 Copay ¹⁶
Drug/Substance Abuse In-Patient (Detox Only)	\$600 Copay per day – 5 days max	50%	80% ¹⁵
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	VSP Choice Network 100% (ded waived) ¹¹ 100% (in lieu of eyeglasses; ded waived) ^{11, 12} 100% (ded waived) ^{11, 12} 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ⁵ 100% 100% \$25 Copay ¹ \$350 Copay ² \$350 Copay	Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ⁵ 100% 100% \$25 Copay ¹ \$350 Copay ² \$350 Copay	Delta Dental DeltaCare USA None Combined with Medical Copay varies by service (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) \$1,000 Copay (ded waived)

* 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 \$350 for a family with one child and \$700 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 \$2,700 for the 2018 benefit year. Once an individual Family Member's Deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other Family Members will be required to continue to contribute to the Deductible until the Family Deductible is met. In Family coverage, an individual Family Member's out of pocket contribution is limited to the individual (self only) annual OOPM amount.
- 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 is met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day Copay price, through the mail-order form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
- 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 through the end of the month in which the member turns 19 years of age as part of the essential health benefit for pediatric vision.
- Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.

(Footnotes continued on page 32)



Gold HMO

Groups Beginning 4/1/18

Services	HMO B	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Alliance
Metal Tier	Gold	Gold	Gold
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	\$6,000 / \$12,000 ⁶	\$5,500 / \$11,000 ²	\$5,500 / \$11,000 ²
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$25 Copay ⁷	\$30 Copay	\$30 Copay
Specialist Visit (SPC)	\$55 Copay	\$50 Copay	\$50 Copay
Laboratory	\$35 Copay	\$25 Copay	\$25 Copay
X-Ray	\$55 Copay per procedure	\$25 Copay	\$25 Copay
MRI, CT and PET (office setting)	\$275 Copay per procedure	\$200 Copay per procedure	\$200 Copay per procedure
Hospital Services – In-Patient	\$600 Copay per day – 5 days max per admit	70%	70%
In-Patient Physician Fees	100%	70%	70%
Emergency Room (copay waived if admitted)	\$325 Copay	70%	70%
Urgent Care	\$25 Copay	\$75 Copay	\$75 Copay
Hospital Services – Out-Patient			
Surgical Facility	\$300 Copay	70%	70%
Ambulatory Surgery Center	\$300 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
Rx Benefits			
Generic	\$15 Copay ⁸	\$15 Copay	\$15 Copay
Formulary Brand	\$55 Copay ^{8,9}	\$35 Copay ³	\$35 Copay ³
Non-Formulary Brand	\$75 Copay ^{8,9}	\$70 Copay ³	\$70 Copay ³
Specialty	80% (up to \$250 per prescription ⁵) ^{8,9}	75% (up to \$250 per prescription ⁵) ³	75% (up to \$250 per prescription ⁵) ³
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay ⁸	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	80%	\$150 Copay ⁴	\$150 Copay ⁴
Chiropractic (20 visits max per year)	Not Covered	\$15 Copay	\$15 Copay
Acupuncture	\$25 Copay	\$10 Copay	\$10 Copay
Physical, Occupational, Speech Therapy	\$25 Copay	\$30 Copay	\$30 Copay
Rehabilitative & Habilitative Services and Devices	\$25 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
Metal Tier	Gold	Gold	Gold
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$300 Copay per day – 5 days max per admit	70%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80%	\$50 Copay	\$50 Copay
Mental Health			
In-Patient	\$600 Copay per day – 5 days max per admit ¹²	70%	70%
Out-Patient (office visit)	\$25 Copay ¹³	\$30 Copay	\$30 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	\$600 Copay per day – 5 days max per admit ¹²	70%	70%
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	Choice Network	Spectera Eyecare Networks	Spectera Eyecare Networks
Exam	100% ¹⁰	100%	100%
Contact Lenses	100% (in lieu of eyeglasses) ^{10,11}	70%	70%
Frames	100% ^{10,11}	70%	70%
Maximum Allowance per year	1 pair per year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	Delta Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	DeltaCare USA	CA DHMO	CA DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	\$1,000 Copay	\$1,000 Copay	\$1,000 Copay

* 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.
- 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 is met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day Copay price, through the mail-order form. Prescription drug deductibles or Copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum.
- 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 through the end of the month in which the member turns 19 years of age as part of the essential health benefit for pediatric vision.
- 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 4/1/18

Services	HMO C	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	Gold	Gold	Gold
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	\$5,500 / \$11,000 ⁶	\$6,750 / \$13,500 ¹	\$6,000 / \$12,000 ¹
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$30 Copay	\$40 Copay	\$25 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
Hospital Services – In-Patient	70%	\$600 Copay per day	\$600 Copay per day – Days 1-5
In-Patient Physician Fees	70%	100%	100%
Emergency Room (copay waived if admitted)	70%	\$300 Copay	\$325 Copay
Urgent Care	\$75 Copay	\$100 Copay	\$25 Copay
Hospital Services – Out-Patient			
Surgical Facility	70%	\$300 Copay	\$300 Copay
Ambulatory Surgery Center	70%	\$300 Copay	\$300 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
Rx Benefits			
Generic	\$15 Copay	\$20 Copay	\$15 Copay
Formulary Brand	\$35 Copay ⁷	\$50 Copay ¹²	\$55 Copay ¹²
Non-Formulary Brand	\$70 Copay ⁷	\$75 Copay ¹²	\$75 Copay ¹²
Specialty	75% (up to \$250 per prescription ⁹) ⁷	80% (up to \$250 per 30 day supply ⁹) ³	80% (up to \$250 per 30 day supply ⁹) ³
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay ⁷	\$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% ⁵	100% ^{2,5}	100% ^{2,5}
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	\$150 Copay ⁸	100%	80%
Chiropractic (20 visits max per year)	\$15 Copay	\$15 Copay ¹¹	\$15 Copay ¹¹
Acupuncture	\$10 Copay	\$15 Copay	\$15 Copay
Physical, Occupational, Speech Therapy	\$30 Copay	\$40 Copay	\$25 Copay
Rehabilitative & Habilitative Services and Devices	\$30 Copay	\$40 Copay	\$25 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
Metal Tier	Gold	Gold	Gold
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% ^{3,4}	80% ^{3,4}
Mental Health In-Patient Out-Patient (office visit)	70% \$30 Copay	\$600 Copay per day \$40 Copay	\$600 Copay per day – Days 1-5 \$25 Copay
Drug/Substance Abuse In-Patient (Detox Only)	70%	\$600 Copay per day	\$600 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	Not Covered Not Covered Not Covered Not Covered 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	MES Vision Eyewear Only 100% 100% 100% 1 per calendar year ¹⁰	MES Vision Eyewear Only 100% 100% 100% 1 per calendar year ¹⁰
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	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.
- 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 4/1/18

Services	HMO C	HMO D [†]	HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	
Network Name	Full	Full	
Metal Tier	Gold	Gold	
Calendar Year Deductible*	\$1,000 / \$2,000 ^{1,7} (applies to Max OOP)	\$2,000 / \$2,700 / \$4,000 ^{1,11} (combined Med/Rx ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$6,750 / \$13,500 ^{2,7}	\$4,000 / \$8,000 ²	
Lifetime Maximum	Unlimited	Unlimited	
Dr. Office Visits (PCP)	\$40 Copay (ded waived)	100% ¹	
Specialist Visit (SPC)	\$40 Copay (ded waived)	100% ¹	
Laboratory	100% (ded waived)	100% ¹	
X-Ray	100% (ded waived)	100% ¹	
MRI, CT and PET (office setting)	\$250 Copay (ded waived)	100% ¹	
Hospital Services – In-Patient	\$500 Copay per day ¹ – Days 1-5	100% ¹	
In-Patient Physician Fees	100% (ded waived)	100% ¹	
Emergency Room (copay waived if admitted)	\$275 Copay ¹	100% ¹	
Urgent Care	\$50 Copay (ded waived)	100% ¹	
Hospital Services – Out-Patient			
Surgical Facility	\$500 Copay ¹	100% ¹	
Ambulatory Surgery Center	\$500 Copay ¹	100% ¹	
Hospital Pre-Authorization	Required	Required	
2nd Surgical Opinion	\$40 Copay (ded waived)	100% ¹	
Ambulance Services (per trip)	100% (ded waived)	100% ¹	
Rx Benefits			
Generic	\$10 Copay (ded waived)	100% ¹ (combined Med/Rx ded)	
Formulary Brand	\$250 / \$500 Ded – \$50 Copay ^{1,12}	\$30 Copay (combined Med/Rx ded) ^{1,12}	
Non-Formulary Brand	\$250 / \$500 Ded – \$75 Copay ^{1,12}	\$50 Copay (combined Med/Rx ded) ^{1,12}	
Specialty	\$250 / \$500 Ded – 80% (up to \$250 per 30 day supply) ^{9,10}	80% (up to \$250 per 30 day supply ⁹) (combined Med/Rx ded) ^{1,10}	
Oral Contraceptives	100% (ded waived)	100% (ded waived)	
Diabetes – Self-Injectable	\$250 / \$500 Ded – \$30 Copay ¹	100% ¹ (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) ^{3,5}	100% (ded waived) ^{3,5}	
Chronic Disease Management	Covered as any Illness	Covered as any Illness	
Chemotherapy	100% (ded waived)	100% ¹	
Chiropractic (20 visits max per year)	\$15 Copay (ded waived) ⁸	100% ¹	
Acupuncture	\$15 Copay (ded waived)	100% ¹	
Physical, Occupational, Speech Therapy	\$40 Copay (ded waived)	100% ¹	
Rehabilitative & Habilitative Services and Devices	\$40 Copay (ded waived)	100% ¹	
Home Health Care (Max 100 visits per year)	100% (ded waived)	100% ¹	

Services	HMO C	HMO D†	HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	
Network Name	Full	Full	
Metal Tier	Gold	Gold	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$500 Copay per day ¹ – Days 1-5	100% ¹	
Hospice	100% (ded waived)	100% ¹	
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) ^{4, 10}	100% ¹⁴	
Mental Health In-Patient Out-Patient (office visit)	\$500 Copay per day ¹ – Days 1-5 \$40 Copay (ded waived)	100% ¹ 100% ¹	
Drug/Substance Abuse In-Patient (Detox Only)	\$500 Copay per day ¹ – Days 1-5	100% ¹	
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year ⁶	MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year ⁶	
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay	Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service \$1,000 Copay	

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount 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 4/1/18

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	Gold		Gold	
	In-Network	Out-of-Network ⁹	In-Network	Out-of-Network ⁹
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 ¹	\$12,000 / \$24,000 ¹	\$4,500 / \$9,000 ¹	\$9,000 / \$18,000 ¹
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	\$30 Copay (ded waived)	50%	\$25 Copay (ded waived)	50%
Specialist Visit (SPC)	\$60 Copay (ded waived)	50%	\$50 Copay (ded waived)	50%
Laboratory	80%	50%	80%	50%
X-Ray	80%	50%	80%	50%
MRI, CT and PET (office setting)	80% ¹⁴	50% (up to \$800 per test) ⁵	80% ¹⁴	50% (up to \$800 per test) ⁵
Hospital Services – In-Patient	Tier 1: 80% Tier 2: \$500 Copay per admit – 80%	50% (up to \$650 per day) ⁵	80%	50% (up to \$650 per day) ⁵
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	\$250 Copay – 80%		\$250 Copay – 80%	
Urgent Care	\$30 Copay (ded waived)	50%	\$50 Copay (ded waived)	50%
Hospital Services – Out-Patient				
Surgical Facility	Tier 1: 80% Tier 2: \$250 Copay per admit – 80%	50% (up to \$380 per admit) ⁵	80%	50% (up to \$380 per admit) ⁵
Ambulatory Surgery Center	Tier 1: 80% Tier 2: \$250 Copay per admit – 80%	50% (up to \$380 per admit) ⁵	80%	50% (up to \$380 per admit) ⁵
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	\$60 Copay (ded waived)	50%	\$50 Copay (ded waived)	50%
Ambulance Services (per trip)	80% ¹³		80% ¹³	
Rx Benefits				
Generic	\$5 Copay / \$20 Copay (overall ded waived) ²	Not Covered	\$5 Copay / \$20 Copay (ded waived) ²	Not Covered
Formulary Brand	\$40 Copay (overall ded waived) ²	Not Covered	\$250 / \$500 Ded – \$40 Copay ²	Not Covered
Non-Formulary Brand	\$80 Copay (overall ded waived) ²	Not Covered	\$250 / \$500 Ded – \$80 Copay ²	Not Covered
Specialty	70% (up to \$250 per prescription ⁸) (overall ded waived) (prior auth. required) ^{2,6}	Not Covered	\$250 / \$500 Ded – 70% (up to \$250 per prescription ⁸) (prior auth. required) ^{2,6}	Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) ²	Not Covered	Applicable Ded / Rx Copay ²	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) ³	50% ³	100% (ded waived) ³	50% ³
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	80%	50% ¹⁴	80%	50% ¹⁴
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) ¹⁰	Not Covered	50% (ded waived) (20 visits max per benefit period) ¹⁰	Not Covered

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	Gold		Gold	
	In-Network	Out-of-Network ⁹	In-Network	Out-of-Network ⁹
Acupuncture	\$30 Copay (ded waived)	Not Covered	\$25 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	80%	50% ¹⁴	80%	50% ¹⁴
Rehabilitative & Habilitative Services and Devices	80% ¹¹	50% ¹¹	80% ¹¹	50% ¹¹
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) ⁴	50% (up to \$75 per visit) (Max 100 visits per benefit period) ^{4,5}	80% (Max 100 visits per benefit period) ⁴	50% (up to \$75 per visit) (Max 100 visits per benefit period) ^{4,5}
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 80% ¹² Tier 2: \$500 Copay per admit – 80% ¹²	50% (up to \$150 per day) ^{5,12}	80% ¹²	50% (up to \$150 per day) ^{5,12}
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%	50%
Mental Health				
In-Patient	Tier 1: 80% Tier 2: \$500 Copay per admit – 80%	50% (up to \$650 per day) ⁵	80%	50% (up to \$650 per day) ⁵
Out-Patient (office visit)	\$30 Copay (ded waived)	50%	\$25 Copay (ded waived)	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	Tier 1: 80% Tier 2: \$500 Copay per admit – 80%	50% (up to \$650 per day) ⁵	80%	50% (up to \$650 per day) ⁵
Infertility				
Infertility Evaluation and Treatment	\$30 Copay (ded waived) ⁷	50% ⁷	\$25 Copay (ded waived) ⁷	50% ⁷
Infertility Drugs	Not Covered	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision				
Carrier	Anthem Vision	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision		Blue View Vision	
Exam	100% (ded waived)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	100% (ded waived)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Contact Lenses	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)
Frames	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental				
Carrier	Anthem Dental	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime		Prime	
Deductible	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)	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%

(Footnotes continued on page 32)

Gold PPO

Groups Beginning 4/1/18

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	Gold		Gold	
	In-Network	Out-of-Network ⁹	In-Network	Out-of-Network ⁹
Calendar Year Deductible*	\$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 ¹	\$8,000 / \$16,000 ¹	\$3,500 / \$7,000 ¹	\$7,000 / \$14,000 ¹
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	\$30 Copay (ded waived)	50%	\$20 Copay (ded waived)	50%
Specialist Visit (SPC)	\$60 Copay (ded waived)	50%	\$40 Copay (ded waived)	50%
Laboratory	80%	50%	80%	50%
X-Ray	80%	50%	80%	50%
MRI, CT and PET (office setting)	80% ¹⁴	50% (up to \$800 per test) ⁵	80% ¹⁴	50% (up to \$800 per test) ⁵
Hospital Services – In-Patient	\$500 Copay per admit	50% (up to \$650 per day) ⁵	80%	50% (up to \$650 per day) ⁵
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	\$250 Copay – 80%		\$250 Copay – 80%	
Urgent Care	\$30 Copay (ded waived)	50%	\$50 Copay (ded waived)	50%
Hospital Services – Out-Patient				
Surgical Facility	\$250 Copay per admit – 80%	50% (up to \$380 per admit) ⁵	80%	50% (up to \$380 per admit) ⁵
Ambulatory Surgery Center	\$250 Copay per admit – 80%	50% (up to \$380 per admit) ⁵	80%	50% (up to \$380 per admit) ⁵
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	\$60 Copay (ded waived)	50%	\$40 Copay (ded waived)	50%
Ambulance Services (per trip)	80% ¹³		80% ¹³	
Rx Benefits				
Generic	\$5 Copay / \$20 Copay (overall ded waived) ²	Not Covered	\$5 Copay / \$20 Copay (ded waived) ²	Not Covered
Formulary Brand	\$40 Copay (overall ded waived) ²	Not Covered	\$250 / \$500 Ded – \$40 Copay ²	Not Covered
Non-Formulary Brand	\$80 Copay (overall ded waived) ²	Not Covered	\$250 / \$500 Ded – \$80 Copay ²	Not Covered
Specialty	70% (up to \$250 per prescription ⁸) (overall ded waived) (prior auth. required) ^{2,6}	Not Covered	\$250 / \$500 Ded – 70% (up to \$250 per prescription ⁸) (prior auth. required) ^{2,6}	Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) ²	Not Covered	Applicable Ded / Rx Copay ²	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) ³	50% ³	100% (ded waived) ³	50% ³
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	80%	50% ¹⁴	80%	50% ¹⁴
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) ¹⁰	Not Covered	50% (ded waived) (20 visits max per benefit period) ¹⁰	Not Covered
Acupuncture	\$30 Copay (ded waived)	Not Covered	\$20 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	80%	50% ¹⁴	80%	50% ¹⁴

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	Gold		Gold	
	In-Network	Out-of-Network ⁹	In-Network	Out-of-Network ⁹
Rehabilitative & Habilitative Services and Devices	80% ¹¹	50% ¹¹	80% ¹¹	50% ¹¹
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) ⁴	50% (up to \$75 per visit) (Max 100 visits per benefit period) ^{4,5}	80% (Max 100 visits per benefit period) ⁴	50% (up to \$75 per visit) (Max 100 visits per benefit period) ^{4,5}
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$500 Copay per admit ¹²	50% (up to \$150 per day) ^{5,12}	80% ¹²	50% (up to \$150 per day) ^{5,12}
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%	50%
Mental Health				
In-Patient	\$500 Copay per admit	50% (up to \$650 per day) ⁵	80%	50% (up to \$650 per day) ⁵
Out-Patient (office visit)	\$30 Copay (ded waived)	50%	\$20 Copay (ded waived)	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	\$500 Copay per admit	50% (up to \$650 per day) ⁵	80%	50% (up to \$650 per day) ⁵
Infertility				
Infertility Evaluation and Treatment	\$30 Copay (ded waived) ⁷	50% ⁷	\$20 Copay (ded waived) ⁷	50% ⁷
Infertility Drugs	Not Covered	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision				
Carrier	Anthem Vision	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision		Blue View Vision	
Exam	100% (ded waived)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	100% (ded waived)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Contact Lenses	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)
Frames	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental				
Carrier	Anthem Dental	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime	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)	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%

(Footnotes continued on page 32)

Additional Footnotes

Groups Beginning 4/1/18

Gold HMO

(Footnotes continued from page 21)

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

(Footnotes continued from page 31)

- * All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
 2. The four prescription drug tiers are: tier 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. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
 10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
 11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
 12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
 13. Medical emergency only.
 14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold PPO

(Footnotes continued from page 29)

- * All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
 2. The four prescription drug tiers are: tier 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. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
 10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
 11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
 12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
 13. Medical emergency only.
 14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

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