

Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4/1/19

Silver/Bronze



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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.

Silver HMO

Groups Beginning 4/1/19

Services	HMO A	HMO A	HMO B
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	WholeCare	CommunityCare
Metal Tier	Silver	Silver	Silver
Calendar Year Deductible*	\$2,100 / \$4,200 ² (combined Med/Pediatric dental ded) (applies to Max OOP)	None	None
Out-of-Pocket Max Ind/Fam	\$7,900 / \$15,800 ³	\$7,350 / \$14,700	\$7,350 / \$14,700
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$55 Copay (ded waived)	\$45 Copay	\$45 Copay
Specialist Visit (SPC)	\$85 Copay (ded waived)	\$60 Copay	\$60 Copay
Laboratory	\$50 Copay (ded waived) ¹²	\$40 Copay	\$40 Copay
X-Ray	\$75 Copay (ded waived) ¹²	\$50 Copay	\$50 Copay
MRI, CT and PET (office setting)	\$150 Copay per test (ded waived) ¹⁴	\$300 Copay per procedure	\$300 Copay per procedure
Hospital Services – In-Patient	60%	50%	50%
In-Patient Physician Fees	100% (ded waived)	50%	50%
Emergency Room (copay waived if admitted)	\$350 Copay – 60%	50%	50%
Urgent Care	\$55 Copay (ded waived)	\$60 Copay	\$60 Copay
Hospital Services – Out-Patient			
Surgical Facility	60%	50%	50%
Ambulatory Surgery Center	60%	60% ²¹	60% ²¹
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$85 Copay (ded waived)	\$60 Copay	\$60 Copay
Ambulance Services (per trip)	60% ⁸	50%	50%
Rx Benefits			
Generic	\$5 Copay / \$20 Copay (ded waived) ⁹	\$20 Copay (ded waived) ^{15, 16}	\$20 Copay (ded waived) ^{15, 16}
Formulary Brand	\$300 / \$600 Ded – \$70 Copay ⁹	\$500 / \$1,000 Ded – 50% (up to \$250 per prescription) ^{7, 15, 16}	\$500 / \$1,000 Ded – 50% (up to \$250 per prescription) ^{7, 15, 16}
Non-Formulary Brand	\$300 / \$600 Ded – \$110 Copay ⁹	\$500 / \$1,000 Ded – 50% (up to \$250 per prescription) ^{7, 15, 16}	\$500 / \$1,000 Ded – 50% (up to \$250 per prescription) ^{7, 15, 16}
Specialty	\$300 / \$600 Ded – 70% (up to \$250 per prescription ⁷) (prior auth. required) ^{5, 9}	\$500 / \$1,000 Ded – 50% (up to \$250 per prescription ⁷) (prior auth. required) ^{15, 16}	\$500 / \$1,000 Ded – 50% (up to \$250 per prescription ⁷) (prior auth. required) ^{15, 16}
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Ded / Rx Copay ⁹	\$500 / \$1,000 Ded – Applicable Rx Copay ^{15, 16}	\$500 / \$1,000 Ded – Applicable Rx Copay ^{15, 16}
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ¹	100% ¹	100% ¹
Chronic Disease Management	Covered as any Illness	\$60 Copay	\$60 Copay
Chemotherapy	60% (ded waived) ¹⁰	100%	100%
Chiropractic (20 visits max per year)	\$55 Copay (ded waived) (20 visits max per benefit period) ¹¹	Not Covered	Not Covered
Acupuncture	\$55 Copay (ded waived)	\$10 Copay	\$10 Copay
Physical, Occupational, Speech Therapy	\$55 Copay (ded waived) ¹²	\$45 Copay	\$45 Copay
Rehabilitative & Habilitative Services and Devices	\$55 Copay (ded waived) ¹²	\$45 Copay	\$45 Copay

Services	HMO A	HMO A	HMO B
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	WholeCare	CommunityCare
Metal Tier	Silver	Silver	Silver
Home Health Care (Max 100 visits per year)	\$85 Copay (ded waived) (Max visits per benefit period) ⁴	\$45 Copay	\$45 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% ¹³	\$25 Copay per day (no limit)	\$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health			
In-Patient	60%	50% ²⁰	50% ²⁰
Out-Patient (office visit)	\$55 Copay (ded waived)	\$45 Copay ²⁰	\$45 Copay ²⁰
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	50%	50%
Infertility			
Infertility Evaluation and Treatment	\$55 Copay (ded waived) ⁶	50% ¹⁷	Not Covered
Infertility Drugs	Not Covered	50% ¹⁷	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	50% ¹⁷	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	EyeMed ¹⁹	EyeMed ¹⁹
Network	Blue View Vision	EyeMed	EyeMed
Exam	100% (ded waived)	100%	100%
Contact Lenses	1 pair per calendar year	100%	100%
Frames	1 pair per calendar year (ded waived)	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 ^{18, 19}	Dental Benefit Providers ^{18, 19}
Network	Prime	Dental Benefit Providers	Dental Benefit Providers
Deductible	Combined Med/Pediatric dental ded	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% (ded waived)	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.

- See plan specific EOC for information on preventive services.
- Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
- Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
- Limited to 100 4-hour visits per benefit period.
- Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
- Evaluation only.
- Maximum member responsibility.
- Medical emergency only.
- The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
- In an office setting.
- Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
- Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
- Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
- Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
- 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.
- Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.
- 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.
- Pediatric dental and vision are included on all plans.
- Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
- Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.



Silver HMO & HSP

Groups Beginning 4/1/19

Services	HSP A	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	Silver	Silver	Silver
Calendar Year Deductible*	\$1,500 / \$3,000 (applies to Max OOP)	\$1,800 / \$3,600 ⁶ (applies to Max OOP)	\$1,000 / \$2,000 ⁶ (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$7,150 / \$14,300	\$7,550 / \$15,100 ⁷	\$7,550 / \$15,100 ⁷
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$30 Copay ⁴	\$55 Copay (ded waived)	\$55 Copay (ded waived)
Specialist Visit (SPC)	\$45 Copay ⁴	\$75 Copay (ded waived)	\$75 Copay (ded waived)
Laboratory	\$30 Copay	\$50 Copay	\$50 Copay (ded waived)
X-Ray	\$30 Copay	\$55 Copay	\$70 Copay (ded waived)
MRI, CT and PET (office setting)	\$300 Copay per procedure	\$350 Copay per procedure	\$350 Copay per procedure
Hospital Services – In-Patient	50%	55%	65%
In-Patient Physician Fees	50%	55%	65%
Emergency Room (copay waived if admitted)	50%	55%	65%
Urgent Care	\$45 Copay	\$55 Copay (ded waived)	\$55 Copay (ded waived)
Hospital Services – Out-Patient			
Surgical Facility	50%	55%	65%
Ambulatory Surgery Center	50% ¹⁴	55%	65%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$45 Copay	55%	65%
Ambulance Services (per trip)	50%	55%	65%
Rx Benefits			
Generic	\$10 Copay (overall ded waived)	\$30 Copay (ded waived)	\$30 Copay (ded waived)
Formulary Brand	\$30 Copay (overall ded waived)	\$350 Ded - \$75 Copay	\$250 Ded - \$75 Copay
Non-Formulary Brand	50% (up to \$250 per prescription ¹²) (overall ded waived)	\$350 Ded - \$75 Copay (with physician approval)	\$250 Ded - \$75 Copay (with physician approval)
Specialty	50% (up to \$250 per prescription ¹²) (overall ded waived)	\$350 Ded - 80% (up to \$250 per prescription ¹²) (with physician approval)	\$250 Ded - 80% (up to \$250 per prescription ¹²) (with physician approval)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	50% (overall ded waived)	\$350 Ded - \$75 Copay	\$250 Ded - \$75 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% (ded waived) ⁵	100% (ded waived) ⁵
Chronic Disease Management	\$45 Copay	55%	\$40 Copay
Chemotherapy	50%	100% (ded waived)	100% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	\$15 Copay (ded waived) ¹³	\$15 Copay (ded waived) ¹³
Acupuncture	\$10 Copay	\$55 Copay (ded waived) ¹³	\$55 Copay (ded waived) ¹³
Physical, Occupational, Speech Therapy	\$30 Copay	\$65 Copay (ded waived)	\$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	\$30 Copay	\$65 Copay (ded waived)	\$65 Copay (ded waived)
Home Health Care (Max 100 visits per year)	50%	100% (ded waived) ¹	100% (ded waived) ¹

Services	HSP A	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	Silver	Silver	Silver
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50% (no limit)	55%	65%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	55% (ded waived) ⁸	65% (ded waived) ⁸
Mental Health			
In-Patient	50%	55%	65%
Out-Patient (office visit)	\$30 Copay	\$55 Copay (ded waived)	\$55 Copay (ded waived)
Drug/Substance Abuse			
In-Patient (Detox Only)	50%	55%	65%
Infertility			
Infertility Evaluation and Treatment	50% ⁹	Not Covered	Not Covered
Infertility Drugs	50% ⁹	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	50% ⁹	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	EyeMed ¹⁰	Kaiser Permanente	Kaiser Permanente
Network	EyeMed	Kaiser Permanente	Kaiser Permanente
Exam	100%	100% (ded waived)	100% (ded waived)
Contact Lenses	100%	1 pair per calendar year ¹⁵	1 pair per calendar year ¹⁵
Frames	1 pair per calendar year	1 pair per calendar year (ded waived) ¹⁵	1 pair per calendar year (ded waived) ¹⁵
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Dental Benefit Providers ^{10,11}	Delta Dental	Delta Dental
Network	Dental Benefit Providers	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	\$350 / \$700	\$350 / \$700
Office Visit	100%	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100%	100% (ded waived)	100% (ded waived)
Basic Services	Copay varies by service	\$95 Copay ²	\$95 Copay ²
Major Services (no waiting period)	Copay varies by service	\$365 Copay ³	\$365 Copay ³
Orthodontics (medically necessary)	Copay varies by service	\$350 Copay	\$350 Copay

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

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

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

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

4. 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.

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

6. 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.

7. 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.

8. 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.

9. Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.

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

11. 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.

12. Maximum member responsibility.

13. 20 visits max per year combined for Chiropractic and Acupuncture.

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

15. 1 pair of glasses or 1 pair of contact lenses per accumulation period.



Silver HMO

Groups Beginning 4/1/19

Services	HMO C	HMO D [†]	HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente		Sharp
Network Name	Full	Full		Premier
Metal Tier	Silver	Silver		Silver
Calendar Year Deductible*	\$2,000 / \$4,000 ¹³ (applies to Max OOP)	\$2,500 / \$2,700 / \$5,000 ⁷ (combined Med/Rx ded) (applies to Max OOP)		\$2,100 / \$4,200 ² (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$7,550 / \$15,100 ⁸	\$6,650 / \$13,300 ⁸		\$7,900 / \$15,800 ^{2,12}
Lifetime Maximum	Unlimited	Unlimited		Unlimited
Dr. Office Visits (PCP)	\$45 Copay (ded waived)	80%		\$40 Copay (ded waived)
Specialist Visit (SPC)	\$80 Copay (ded waived)	80%		\$70 Copay (ded waived)
Laboratory	\$40 Copay (ded waived)	80%		\$30 Copay
X-Ray	\$75 Copay (ded waived)	80%		\$60 Copay
MRI, CT and PET (office setting)	\$300 Copay per procedure (ded waived)	80% per procedure		\$250 Copay per procedure
Hospital Services – In-Patient	80%	80%		\$750 Copay per day
In-Patient Physician Fees	80%	80%		100%
Emergency Room (copay waived if admitted)	\$350 Copay (ded waived)	80%		\$400 Copay
Urgent Care	\$45 Copay (ded waived)	80%		\$70 Copay (ded waived)
Hospital Services – Out-Patient				
Surgical Facility	80% (ded waived)	80%		50%
Ambulatory Surgery Center	80% (ded waived)	80%		50%
Hospital Pre-Authorization	Required	Required		Required
2nd Surgical Opinion	80%	80%		\$70 Copay (ded waived)
Ambulance Services (per trip)	\$250 Copay	80%		\$400 Copay (ded waived)
Rx Benefits				
Generic	\$200 Ded – \$15 Copay	80% (combined Med/Rx ded)		\$20 Copay (ded waived)
Formulary Brand	\$200 Ded – \$55 Copay	80% (combined Med/Rx ded)		\$200 / \$400 Ded – \$50 Copay
Non-Formulary Brand	\$200 Ded – \$55 Copay (with physician approval)	80% (combined Med/Rx ded) (with physician approval)		\$200 / \$400 Ded – \$80 Copay
Specialty	\$200 Ded – 80% (up to \$250 per prescription ⁹) (with physician approval)	80% (up to \$250 per prescription ⁹) (combined Med/Rx ded) (with physician approval)		\$200 / \$400 Ded – Applicable Rx Copay
Oral Contraceptives	100%	100%		100% (if in formulary)
Diabetes – Self-Injectable	\$200 Ded – \$55 Copay	80% (combined Med/Rx ded)		\$200 / \$400 Ded – Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered		Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness		Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ¹	100% (ded waived) ¹		100% (ded waived) ¹
Chronic Disease Management	80%	80%		\$70 Copay (ded waived)
Chemotherapy	80% (ded waived)	80%		Variable ⁶
Chiropractic (20 visits max per year)	Not Covered	Not Covered		Not Covered
Acupuncture	\$45 Copay (ded waived)	80%		\$40 Copay (ded waived)
Physical, Occupational, Speech Therapy	\$45 Copay (ded waived)	80%		\$40 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	\$45 Copay (ded waived)	80%		\$40 Copay (ded waived)
Home Health Care (Max 100 visits per year)	\$45 Copay (ded waived) ¹⁰	80% ¹⁰		\$40 Copay (ded waived)

Services	HMO C	HMO D [†]	HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente		Sharp
Network Name	Full	Full		Premier
Metal Tier	Silver	Silver		Silver
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%		\$200 Copay per day
Hospice (out-patient)	100% (ded waived)	100%		100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) ¹⁴	80% ¹⁴		50%
Mental Health In-Patient Out-Patient (office visit)	80% \$45 Copay (ded waived)	80% 80%		\$750 Copay per day \$40 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	80%	80%		\$750 Copay per day
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 ¹¹ 1 pair per calendar year (ded waived) ¹¹ None	Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year ¹¹ 1 pair per calendar year (ded waived) 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% (ded waived) 100% (ded waived) \$95 Copay ⁴ \$365 Copay ⁵ \$350 Copay	Delta Dental DeltaCare USA None \$350 / \$700 100% (ded waived) 100% (ded waived) \$95 Copay ⁴ \$365 Copay ⁵ \$350 Copay		Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ³ 100% 100% \$25 Copay ⁴ \$350 Copay ⁴ \$350 Copay

[†] HSA Qualified High Deductible Plan

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

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

2. 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.

3. 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.

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

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

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

7. \$2,500 Self only enrollment, \$2,700 for any one member within a Family enrollment. \$5,000 for an entire Family. Does not apply to preventive care.

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

9. Maximum member responsibility.

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

11. 1 pair of glasses or 1 pair of contact lenses per accumulation period.

12. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.

13. 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.

14. 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.



Silver HMO

Groups Beginning 4/1/19

Services	HMO B	HMO C	HMO B
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Sutter Health Plus
Metal Tier	Silver	Silver	Silver
Calendar Year Deductible*	\$2,100 / \$4,200 ¹³ (applies to Max OOP)	\$2,000 / \$4,000 ¹³ (applies to Max OOP)	\$2,000 / \$4,000 ¹ (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$7,900 / \$15,800 ^{13, 14}	\$7,900 / \$15,800 ^{13, 14}	\$7,550 / \$15,100 ²
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$40 Copay (ded waived)	\$40 Copay (ded waived)	\$45 Copay (ded waived) ⁸
Specialist Visit (SPC)	\$70 Copay (ded waived)	\$70 Copay (ded waived)	\$80 Copay (ded waived)
Laboratory	\$15 Copay	\$50 Copay	\$40 Copay (ded waived)
X-Ray	\$30 Copay	\$50 Copay	\$75 Copay per procedure (ded waived)
MRI, CT and PET (office setting)	\$300 Copay per procedure	\$500 Copay per procedure	\$300 Copay per procedure (ded waived)
Hospital Services – In-Patient	60%	50%	80%
In-Patient Physician Fees	60%	50%	80% (ded waived)
Emergency Room (copay waived if admitted)	60%	50%	\$350 Copay (ded waived)
Urgent Care	\$70 Copay (ded waived)	\$70 Copay (ded waived)	\$45 Copay (ded waived)
Hospital Services – Out-Patient			
Surgical Facility	60%	50%	80% (ded waived)
Ambulatory Surgery Center	60%	50%	80% (ded waived)
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$70 Copay (ded waived)	\$70 Copay (ded waived)	\$80 Copay (ded waived)
Ambulance Services (per trip)	60% (ded waived)	50% (ded waived)	\$250 Copay
Rx Benefits			
Generic	\$20 Copay (ded waived)	\$20 Copay (overall ded waived)	\$200 / \$400 Ded – \$15 Copay ³
Formulary Brand	\$200 / \$400 Ded – \$50 Copay	\$50 Copay (overall ded waived)	\$200 / \$400 Ded – \$55 Copay ^{3, 4}
Non-Formulary Brand	\$200 / \$400 Ded – \$100 Copay	\$100 Copay (overall ded waived)	\$200 / \$400 Ded – \$85 Copay ^{3, 4}
Specialty	\$200 / \$400 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)	\$200 / \$400 Ded – 80% (up to \$250 per prescription ⁹) ^{3, 4}
Oral Contraceptives	100% (if in formulary)	100% (overall ded waived)	100% (ded waived)
Diabetes – Self-Injectable	\$200 / \$400 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)	\$200 / \$400 Ded – Applicable Rx Copay ³
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ⁵	100% (ded waived) ⁵	100% (ded waived) ⁵
Chronic Disease Management	\$70 Copay (ded waived)	\$70 Copay (ded waived)	Covered as any Illness
Chemotherapy	Variable ¹⁵	Variable ¹⁵	80% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	\$40 Copay (ded waived)	\$40 Copay (ded waived)	\$45 Copay (ded waived)
Physical, Occupational, Speech Therapy	\$40 Copay (ded waived)	\$40 Copay (ded waived)	\$45 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	\$40 Copay (ded waived)	\$40 Copay (ded waived)	\$45 Copay (ded waived)
Home Health Care (Max 100 visits per year)	\$40 Copay (ded waived)	\$40 Copay (ded waived)	\$45 Copay (ded waived)

Services	HMO B	HMO C	HMO B
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Sutter Health Plus
Metal Tier	Silver	Silver	Silver
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	50%	80%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	80% (ded waived)
Mental Health In-Patient Out-Patient (office visit)	60% \$40 Copay (ded waived)	50% \$40 Copay (ded waived)	80% ¹¹ \$45 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	60%	50%	80% ¹¹
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	VSP Choice Network 100% (ded waived) ⁶ 100% (in lieu of eyeglasses) (ded waived) ^{6,7} 100% (in lieu of contact lenses) (ded waived) ^{6,7} 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ¹⁶ 100% 100% \$25 Copay ¹⁷ \$350 Copay ¹² \$350 Copay	Access Dental Access Dental Plan Children's Dental HMO None \$350 / \$700 ¹⁶ 100% 100% \$25 Copay ¹⁷ \$350 Copay ¹² \$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.

- Family deductibles (when applicable) and out-of-pocket maximums (OOPM) are "embedded". This means that an individual in a family plan is responsible for no more than the "individual family member" deductible and OOPM (please see exceptions below regarding high deductible health plans (HDHPs)). Once an individual family member has met their deductible, that family member will only be responsible for the specified copayment or coinsurance until that individual meets the individual family member OOPM or the family as a whole meets the family OOPM, whichever comes first. Deductibles and other cost sharing payments made by each individual in a family accrue to both the "family" deductible and "family" OOPM. Once the family deductible has been met, individual family members who have not yet met the individual family member OOPM amount will continue to be responsible for the specified copayment or coinsurance until they meet the individual family member OOPM or until the family as a whole meets the "family" OOPM, at which point, Sutter Health Plus pays all costs for covered services for all family members. For HDHPs, in a family plan, an individual family member's deductible must be the higher of the specified "single" deductible amount or the IRS minimum of \$2,700 for 2019 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
- Cost sharing for all essential health benefits, including that which accumulates toward an applicable deductible, accumulates toward the out-of-pocket maximum.
- Copayments apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 2 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription for up to a 30-day supply. For HDHP plans, this \$200 maximum will not apply until after the deductible is met.

- Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
- 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.
- A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
- Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
- Maximum member responsibility.
- Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
- Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
- 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.

(Footnotes continued on page 34)



Silver HMO

Groups Beginning 4/1/19

Services	HMO C [†]	HSA Qualified	HMO A	HMO B
Participating Health Plans	Sutter Health Plus		UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plus		SignatureValue	Advantage
Metal Tier	Silver		Silver	Silver
Calendar Year Deductible*	\$2,200 / \$2,700 / \$4,400 ^{7,10} (combined Med/Rx ded) (applies to Max OOP)		\$2,250 / \$4,500 ⁴ (applies to Max OOP)	\$2,250 / \$4,500 ⁴ (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,000 / \$12,000 ⁹		\$7,900 / \$15,800 ⁵	\$7,900 / \$15,800 ⁵
Lifetime Maximum	Unlimited		Unlimited	Unlimited
Dr. Office Visits (PCP)	\$35 Copay ⁸		\$50 Copay (ded waived)	\$50 Copay (ded waived)
Specialist Visit (SPC)	\$50 Copay		\$75 Copay (ded waived)	\$75 Copay (ded waived)
Laboratory	\$35 Copay		\$40 Copay (ded waived)	\$40 Copay (ded waived)
X-Ray	\$15 Copay per procedure		\$40 Copay (ded waived)	\$40 Copay (ded waived)
MRI, CT and PET (office setting)	\$50 Copay per procedure		\$200 Copay per procedure (ded waived)	\$200 Copay per procedure (ded waived)
Hospital Services – In-Patient	80%		60%	60%
In-Patient Physician Fees	80%		60% (ded waived)	60% (ded waived)
Emergency Room (copay waived if admitted)	80%		60%	60%
Urgent Care	\$35 Copay		\$100 Copay (ded waived)	\$100 Copay (ded waived)
Hospital Services – Out-Patient				
Surgical Facility	80%		60%	60%
Ambulatory Surgery Center	80%		60%	60%
Hospital Pre-Authorization	Required		Required	Required
2nd Surgical Opinion	\$50 Copay		\$75 Copay (ded waived)	\$75 Copay (ded waived)
Ambulance Services (per trip)	80%		\$100 Copay (ded waived)	\$100 Copay (ded waived)
Rx Benefits				
Generic	\$10 Copay (combined Med/Rx ded) ¹¹		\$20 Copay (ded waived)	\$20 Copay (ded waived)
Formulary Brand	\$20 Copay (combined Med/Rx ded) ^{11,12}		\$250 / \$500 Ded – \$50 Copay ²	\$250 / \$500 Ded – \$50 Copay ²
Non-Formulary Brand	\$40 Copay (combined Med/Rx ded) ^{11,12}		\$250 / \$500 Ded – \$100 Copay ²	\$250 / \$500 Ded – \$100 Copay ²
Specialty	80% (up to \$250 per prescription ³) (combined Med/Rx ded) ^{11,12}		\$250 / \$500 Ded – 75% (up to \$250 per prescription ³) ²	\$250 / \$500 Ded – 75% (up to \$250 per prescription ³) ²
Oral Contraceptives	100% (ded waived)		100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (combined Med/Rx ded) ^{11,12}		Applicable Ded / Rx Copay ²	Applicable Ded / Rx Copay ²
Pre-Existing Conditions	Covered		Covered	Covered
Maternity and Newborn Care	Covered as any illness		Covered as any illness	Covered as any illness
Preventive/Wellness Services	100% (ded waived) ¹		100% (ded waived) ¹	100% (ded waived) ¹
Chronic Disease Management	Covered as any illness		Covered as any illness	Covered as any illness
Chemotherapy	80%		\$150 Copay (ded waived) ⁶	\$150 Copay (ded waived) ⁶
Chiropractic (20 visits max per year)	Not Covered		\$15 Copay (ded waived)	\$15 Copay (ded waived)
Acupuncture	\$35 Copay		\$10 Copay (ded waived)	\$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	\$35 Copay		\$50 Copay (ded waived)	\$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	\$35 Copay		\$50 Copay (ded waived)	\$50 Copay (ded waived)
Home Health Care (Max 100 visits per year)	80%		\$50 Copay (ded waived)	\$50 Copay (ded waived)

Services	HMO C [†]	HSA Qualified	HMO A	HMO B
Participating Health Plans	Sutter Health Plus		UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plus		SignatureValue	Advantage
Metal Tier	Silver		Silver	Silver
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%		60%	60%
Hospice (out-patient)	100%		100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80%		\$50 Copay (ded waived)	\$50 Copay (ded waived)
Mental Health In-Patient Out-Patient (office visit)	80% ¹³ \$35 Copay		60% \$50 Copay (ded waived)	60% \$50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	80% ¹³		60%	60%
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
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	VSP Choice Network 100% (ded waived) ¹⁴ 100% (in lieu of eyeglasses) (ded waived) ^{14,15} 100% (in lieu of contact lenses) (ded waived) ^{14,15} 1 pair per year		UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Delta Dental DeltaCare USA None Combined with Medical Copoly varies by service (ded waived) 100% (ded waived) Copoly varies by service (ded waived) Copoly varies by service (ded waived) \$1,000 Copay (ded waived)		UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copoly varies by service Copoly varies by service \$1,000 Copay	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copoly varies by service Copoly varies by service \$1,000 Copay

[†] HSA Qualified High Deductible Plan

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

- See plan specific EOC for information on preventive services.
- For Specialty drugs, please see plan specific EOC.
- Maximum member responsibility.
- The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
- When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
- In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
- Family deductibles (when applicable) and out-of-pocket maximums (OOPM) are "embedded". This means that an individual in a family plan is responsible for no more than the "individual family member" deductible and OOPM (please see exceptions below regarding high deductible health plans (HDHPs)). Once an individual family member has met their deductible, that family member will only be responsible for the specified copayment or coinsurance until that individual meets the individual family member OOPM or the family as a whole meets the family OOPM, whichever comes first. Deductibles and other cost sharing payments made by each individual in a family accrue to both the "family" deductible and "family" OOPM. Once the family deductible has been met, individual family members who have not yet met the individual family member OOPM amount will continue to be responsible for the specified copayment or coinsurance until they meet the individual family member OOPM or until the family as a whole meets the "family" OOPM, at which point, Sutter Health Plus pays all costs for covered services for all family members. For HDHPs, in a family plan, an individual family member's deductible must be the higher of the specified "single" deductible amount or the IRS minimum of \$2,700 for 2019 plans. Cost sharing for non-essential health benefits or optional benefits

electected by a group does not accrue to the deductible or OOPM.

- Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.
- Cost sharing for all essential health benefits, including that which accumulates toward an applicable deductible, accumulates toward the out-of-pocket maximum.
- Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
- Copayments apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 2 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription for up to a 30-day supply. For HDHP plans, this \$200 maximum will not apply until after the deductible is met.
- Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
- Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
- 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.
- A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.



Silver HMO

Groups Beginning 4/1/19

Services	HMO C	HMO D	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Alliance	Focus	Full
Metal Tier	Silver	Silver	Silver
Calendar Year Deductible*	\$2,200 / \$4,400 ¹⁰ (applies to Max OOP)	\$2,250 / \$4,500 ¹⁰ (applies to Max OOP)	\$2,400 / \$4,800 ^{1,13} (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$7,900 / \$15,800 ¹¹	\$7,900 / \$15,800 ¹¹	\$7,550 / \$15,100 ^{2,13}
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	70%	\$50 Copay (ded waived)	\$50 Copay (ded waived)
Specialist Visit (SPC)	70%	\$75 Copay (ded waived)	\$50 Copay (ded waived)
Laboratory	70%	\$40 Copay (ded waived)	\$50 Copay (ded waived)
X-Ray	70%	\$40 Copay (ded waived)	\$50 Copay (ded waived)
MRI, CT and PET (office setting)	70%	\$200 Copay per procedure (ded waived)	\$300 Copay (ded waived)
Hospital Services – In-Patient	70%	60%	80% ^{1,4}
In-Patient Physician Fees	70%	60% (ded waived)	100% (ded waived)
Emergency Room (copay waived if admitted)	70%	60%	80% ^{1,4}
Urgent Care	70%	\$100 Copay (ded waived)	\$100 Copay ¹
Hospital Services – Out-Patient			
Surgical Facility	70%	60%	\$300 Copay ¹
Ambulatory Surgery Center	70%	60%	\$300 Copay ¹
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	70%	\$75 Copay (ded waived)	\$50 Copay (ded waived)
Ambulance Services (per trip)	70%	\$100 Copay (ded waived)	100% (ded waived)
Rx Benefits			
Generic	\$20 Copay (ded waived)	\$20 Copay (ded waived)	\$15 Copay (ded waived)
Formulary Brand	\$250 / \$500 Ded – \$50 Copay ⁹	\$250 / \$500 Ded – \$50 Copay ⁹	\$250 / \$500 Ded – \$55 Copay ^{1,15}
Non-Formulary Brand	\$250 / \$500 Ded – \$100 Copay ⁹	\$250 / \$500 Ded – \$100 Copay ⁹	\$250 / \$500 Ded – \$85 Copay ^{1,15}
Specialty	\$250 / \$500 Ded – 75% (up to \$250 per prescription ⁸) ⁹	\$250 / \$500 Ded – 75% (up to \$250 per prescription ⁸) ⁹	\$250 / \$500 Ded – 80% (up to \$250 per 30 day supply ⁸) ^{1,4}
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay ⁹	Applicable Ded / Rx Copay ⁹	\$250 / \$500 Ded – \$50 Copay ¹
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) ⁶	100% (ded waived) ⁶	100% (ded waived) ^{3,6}
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	70%	\$150 Copay (ded waived) ¹²	100% (ded waived)
Chiropractic (20 visits max per year)	70%	\$15 Copay (ded waived)	\$15 Copay (ded waived) ¹⁴
Acupuncture	70%	\$10 Copay (ded waived)	\$15 Copay (ded waived)
Physical, Occupational, Speech Therapy	70%	\$50 Copay (ded waived)	\$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	70%	\$50 Copay (ded waived)	\$50 Copay (ded waived)
Home Health Care (Max 100 visits per year)	70%	\$50 Copay (ded waived)	100% (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	60%	80% ^{1,4}

Services	HMO C	HMO D	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Alliance	Focus	Full
Metal Tier	Silver	Silver	Silver
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	70%	\$50 Copay (ded waived)	80% (ded waived) ^{4,5}
Mental Health In-Patient Out-Patient (office visit)	70% 70%	60% \$50 Copay (ded waived)	80% ^{1,4} \$50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	70%	60%	80% ^{1,4}
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	Not Covered Not Covered Not Covered Not Covered Not Covered	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% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar year	UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year 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)	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service \$1,000 Copay	UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service \$1,000 Copay	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.

- Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
- The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
- There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
- Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
- See copayment summary for applicable prosthetic/orthotic device copayment amount.
- See plan specific EOC for information on preventive services.
- Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
- Maximum member responsibility.
- For Specialty drugs, please see plan specific EOC.
- The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
- When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
- In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
- The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.
- Copayments do not contribute to out-of-pocket maximum.
- Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier 1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.



Silver HMO

Groups Beginning 4/1/19

Services	HMO B	HMO C [†]	HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	
Network Name	Full	Full	
Metal Tier	Silver	Silver	
Calendar Year Deductible*	\$2,000 / \$4,000 ^{1,10} (applies to Max OOP)	\$2,500 / \$2,700 / \$5,000 ^{1,9,10} (combined Med/Rx ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$7,550 / \$15,100 ^{2,10}	\$6,650 / \$13,300 ^{2,10}	
Lifetime Maximum	Unlimited	Unlimited	
Dr. Office Visits (PCP)	\$45 Copay (ded waived)	80% ^{1,4}	
Specialist Visit (SPC)	\$80 Copay (ded waived)	80% ^{1,4}	
Laboratory	\$40 Copay (ded waived)	80% ^{1,4}	
X-Ray	\$75 Copay (ded waived)	80% ^{1,4}	
MRI, CT and PET (office setting)	\$300 Copay (ded waived)	80% ^{1,4}	
Hospital Services – In-Patient	80% ^{1,4}	80% ^{1,4}	
In-Patient Physician Fees	80% (ded waived) ⁴	80% ^{1,4}	
Emergency Room (copay waived if admitted)	\$350 Copay (ded waived)	80% ^{1,4}	
Urgent Care	\$45 Copay (ded waived)	80% ^{1,4}	
Hospital Services – Out-Patient			
Surgical Facility	80% (ded waived) ⁴	80% ^{1,4}	
Ambulatory Surgery Center	80% (ded waived) ⁴	80% ^{1,4}	
Hospital Pre-Authorization	Required	Required	
2nd Surgical Opinion	\$70 Copay (ded waived)	80% ^{1,4}	
Ambulance Services (per trip)	\$250 Copay ¹	80% ^{1,4}	
Rx Benefits			
Generic	\$200 / \$400 Ded – \$15 Copay	80% (up to \$250 per 30 day supply ⁸) (combined Med/Rx ded) ^{1,4}	
Formulary Brand	\$200 / \$400 Ded – \$55 Copay ^{1,11}	80% (up to \$250 per 30 day supply ⁸) (combined Med/Rx ded) ^{1,4,11}	
Non-Formulary Brand	\$200 / \$400 Ded – \$85 Copay ^{1,11}	80% (up to \$250 per 30 day supply ⁸) (combined Med/Rx ded) ^{1,4,11}	
Specialty	\$200 / \$400 Ded – 80% (up to \$250 per 30 day supply ⁸) ^{1,4}	80% (up to \$250 per 30 day supply ⁸) (combined Med/Rx ded) ^{1,4}	
Oral Contraceptives	100% (ded waived)	100% (ded waived)	
Diabetes – Self-Injectable	\$200 / \$400 Ded – \$55 Copay ¹	80% (up to \$250 per 30 day supply ⁸) (combined Med/Rx ded) ^{1,4}	
Pre-Existing Conditions	Covered	Covered	
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) ^{3,6}	100% (ded waived) ^{3,6}	
Chronic Disease Management	Covered as any Illness	Covered as any Illness	
Chemotherapy	80% ^{1,4}	80% ^{1,4}	
Chiropractic (20 visits max per year)	\$15 Copay (ded waived) ¹²	100% ^{1,12}	
Acupuncture	\$45 Copay (ded waived)	80% ^{1,4}	
Physical, Occupational, Speech Therapy	\$45 Copay (ded waived)	80% ^{1,4}	
Rehabilitative & Habilitative Services and Devices	\$45 Copay (ded waived)	80% ^{1,4}	

Services	HMO B	HMO C [†]	HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	
Network Name	Full	Full	
Metal Tier	Silver	Silver	
Home Health Care (Max 100 visits per year)	\$45 Copay (ded waived)	80% ^{1,4}	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% ^{1,4}	80% ^{1,4}	
Hospice (out-patient)	100% (ded waived)	100% ¹	
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) ^{4,5}	80% ^{1,4,5}	
Mental Health			
In-Patient	80% ^{1,4}	80% ^{1,4}	
Out-Patient (office visit)	\$45 Copay (ded waived)	80% ^{1,4}	
Drug/Substance Abuse			
In-Patient (Detox Only)	80% ^{1,4}	80% ^{1,4}	
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	
Infertility Drugs	Not Covered	Not Covered	
In Vitro Fertilization (IVF)	Not Covered	Not Covered	
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	
Pediatric Vision			
Carrier	MES Vision	MES Vision	
Network	Eyewear Only	Eyewear Only	
Exam	100% (ded waived)	100% (ded waived)	
Contact Lenses	100% (ded waived)	100% (ded waived)	
Frames	100% (ded waived)	100% (ded waived)	
Maximum Allowance per year	1 per calendar year ⁷	1 per calendar year ⁷	
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	
Network	DeltaCare USA	DeltaCare USA	
Deductible	None	None	
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	
Office Visit	100%	100%	
Diagnostic & Preventative (D&P)	100%	100%	
Basic Services	Copay varies by service	Copay varies by service	
Major Services (no waiting period)	Copay varies by service	Copay varies by service	
Orthodontics (medically necessary)	\$1,000 Copay	\$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. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. 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.

8. Maximum member responsibility.

9. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
10. 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.
11. 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.
12. Copayments do not contribute to out-of-pocket maximum.



Silver PPO

Groups Beginning 4/1/19

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	Silver		Silver	
	In-Network	Out-of-Network ⁹	In-Network	Out-of-Network ⁹
Calendar Year Deductible*	\$1,350 / \$2,700 (combined Med/Pediatric dental ded) (applies to Max OOP)	\$2,700 / \$5,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	\$1,700 / \$3,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	\$3,400 / \$6,800 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$7,900 / \$15,800 ¹	\$15,800 / \$31,600 ¹	\$7,900 / \$15,800 ¹	\$15,800 / \$31,600 ¹
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	\$40 Copay (ded waived)	50%	\$45 Copay (ded waived)	50%
Specialist Visit (SPC)	\$80 Copay (ded waived)	50%	\$90 Copay (ded waived)	50%
Laboratory	60%	50%	65%	50%
X-Ray	60%	50%	65%	50%
MRI, CT and PET (office setting)	60%	50% (up to \$800 per test) ⁵	65%	50% (up to \$800 per test) ⁵
Hospital Services – In-Patient	Tier 1: 60% Tier 2: \$500 Copay per admit – 60%	50% (up to \$650 per day) ⁵	\$750 Copay per admit	50% (up to \$650 per day) ⁵
In-Patient Physician Fees	60%	50%	65%	50%
Emergency Room (copay waived if admitted)	\$350 Copay – 60%		\$300 Copay – 65%	
Urgent Care	\$80 Copay (ded waived)	50%	\$90 Copay (ded waived)	50%
Hospital Services – Out-Patient				
Surgical Facility	Tier 1: 60% Tier 2: \$250 Copay per admit – 60%	50% (up to \$380 per admit) ⁵	\$300 Copay per admit – 65%	50% (up to \$380 per admit) ⁵
Ambulatory Surgery Center	Tier 1: 60% Tier 2: \$250 Copay per admit – 60%	50% (up to \$380 per admit) ⁵	\$300 Copay per admit – 65%	50% (up to \$380 per admit) ⁵
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	\$80 Copay (ded waived)	50%	\$90 Copay (ded waived)	50%
Ambulance Services (per trip)	60% ¹³		65% ¹³	
Rx Benefits				
Generic	\$5 Copay / \$20 Copay (ded waived) ²	Not Covered	\$5 Copay / \$20 Copay (ded waived) ²	Not Covered
Formulary Brand	\$325 / \$650 Ded – \$50 Copay ²	Not Covered	\$350 / \$700 Ded – \$50 Copay ²	Not Covered
Non-Formulary Brand	\$325 / \$650 Ded – \$90 Copay ²	Not Covered	\$350 / \$700 Ded – \$90 Copay ²	Not Covered
Specialty	\$325 / \$650 Ded – 70% (up to \$250 per prescription ⁸) (prior auth.required) ^{2,6}	Not Covered	\$350 / \$700 Ded – 70% (up to \$250 per prescription ⁸) (prior auth.required) ^{2,6}	Not Covered
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay 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	60%	50% ¹⁴	65%	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	\$40 Copay (ded waived)	Not Covered	\$45 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	60%	50% ¹⁴	65%	50% ¹⁴

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	Silver		Silver	
	In-Network	Out-of-Network ⁹	In-Network	Out-of-Network ⁹
Rehabilitative & Habilitative Services and Devices	60% ¹¹	50% ¹¹	65% ¹¹	50% ¹¹
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) ⁴	50% (up to \$75 per visit) (Max 100 visits per benefit period) ^{4,5}	65% (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: 60% ¹² Tier 2: \$500 Copay per admit – 60% ¹²	50% (up to \$150 per day) ^{5,12}	\$750 Copay per admit ¹²	50% (up to \$150 per day) ^{5,12}
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%	50%
Mental Health				
In-Patient	Tier 1: 60% Tier 2: \$500 Copay per admit – 60%	50% (up to \$650 per day) ⁵	\$750 Copay per admit	50% (up to \$650 per day) ⁵
Out-Patient (office visit)	\$40 Copay (ded waived)	50%	\$45 Copay (ded waived)	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	Tier 1: 60% Tier 2: \$500 Copay per admit – 60%	50% (up to \$650 per day) ⁵	\$750 Copay per admit	50% (up to \$650 per day) ⁵
Infertility				
Infertility Evaluation and Treatment	\$40 Copay (ded waived) ⁷	50% ⁷	\$45 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 Network Exam	Anthem Vision Blue View Vision 100% (ded waived)	Anthem Vision \$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	Anthem Vision Blue View Vision 100% (ded waived)	Anthem Vision \$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Contact Lenses	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	\$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)
Frames	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year)	100% (ded waived) (1 per calendar year)	\$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental				
Carrier Network Deductible	Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON)	Anthem Dental Combined Med/Pediatric dental ded (IN & OON)	Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON)	Anthem Dental Combined Med/Pediatric dental ded (IN & OON)
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	50%	50%	50%	50%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

(Footnotes continued on page 34)



Silver EPO

Groups Beginning 4/1/19

Services	EPO A	EPO B [†]	HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	Prudent Buyer – Small Group	
Metal Tier	Silver	Silver	
Calendar Year Deductible*	\$2,200 / \$4,400 ² (combined Med/ Pediatric dental ded)(applies to Max OOP)	\$2,000 / \$2,700 / \$4,000 ⁹ (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$7,900 / \$15,800 ³	\$6,750 / \$13,500 ³	
Lifetime Maximum	Unlimited	Unlimited	
Dr. Office Visits (PCP)	\$50 Copay (ded waived)	75%	
Specialist Visit (SPC)	\$100 Copay (ded waived)	75%	
Laboratory	65%	75%	
X-Ray	65%	75%	
MRI, CT and PET (office setting)	65% ¹⁴	75%	
Hospital Services – In-Patient	\$750 Copay per admit	75%	
In-Patient Physician Fees	65%	75%	
Emergency Room (copay waived if admitted)	\$300 Copay – 65%	75%	
Urgent Care	\$100 Copay (ded waived)	75%	
Hospital Services – Out-Patient			
Surgical Facility	\$300 Copay per admit – 65%	75%	
Ambulatory Surgery Center	\$300 Copay per admit – 65%	75%	
Hospital Pre-Authorization	Required	Required	
2nd Surgical Opinion	\$100 Copay (ded waived)	75%	
Ambulance Services (per trip)	65% ⁸	75% ⁸	
Rx Benefits			
Generic	\$5 Copay / \$20 Copay (ded waived) ¹⁰	75% (up to \$250 per prescription ⁷) (combined Med/Rx/Pediatric dental ded) ¹⁰	
Formulary Brand	\$200 / \$400 Ded – \$50 Copay ¹⁰	75% (up to \$250 per prescription ⁷) (combined Med/Rx/Pediatric dental ded) ¹⁰	
Non-Formulary Brand	\$200 / \$400 Ded – \$90 Copay ¹⁰	75% (up to \$250 per prescription ⁷) (combined Med/Rx/Pediatric dental ded) ¹⁰	
Specialty	\$200 / \$400 Ded – 70% (up to \$250 per prescription ⁷) (prior auth. required) ^{5, 10}	75% (up to \$250 per prescription ⁷) (combined Med/Rx/Pediatric dental ded) (prior auth. required) ^{5, 10}	
Oral Contraceptives	100%	100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay ¹⁰	75% (up to \$250 per prescription ⁷) (combined Med/Rx/Pediatric dental ded) ¹⁰	
Pre-Existing Conditions	Covered	Covered	
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) ¹	100% (ded waived) ¹	
Chronic Disease Management	Covered as any Illness	Covered as any Illness	
Chemotherapy	65%	75%	
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per ben- efit period) ¹¹	50% (20 visits max per benefit period) ¹¹	
Acupuncture	\$50 Copay (ded waived)	75%	
Physical, Occupational, Speech Therapy	65%	75%	

Services	EPO A	EPO B †	HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	Prudent Buyer – Small Group	
Metal Tier	Silver	Silver	
Rehabilitative & Habilitative Services and Devices	65% ¹²	75% ¹²	
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) ⁴	75% (Max 100 visits per benefit period) ⁴	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$750 Copay per admit ¹³	75% ¹³	
Hospice (out-patient)	100%	100%	
Durable Medical Equipment (Covered when medically necessary)	50%	50%	
Mental Health			
In-Patient	\$750 Copay per admit	75%	
Out-Patient (office setting)	\$50 Copay (ded waived)	75%	
Drug/Substance Abuse			
In-Patient (Detox Only)	\$750 Copay per admit	75%	
Infertility			
Infertility Evaluation and Treatment	\$50 Copay (ded waived) ⁶	75% ⁶	
Infertility Drugs	Not Covered	Not Covered	
In Vitro Fertilization (IVF)	Not Covered	Not Covered	
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	
Pediatric Vision			
Carrier	Anthem Vision	Anthem Vision	
Network	Blue View Vision	Blue View Vision	
Exam	100% (ded waived)	100% (ded waived)	
Contact Lenses	1 pair per calendar year	100% (in lieu of eyeglasses)	
Frames	1 pair per calendar year (ded waived)	100% (ded waived)	
Maximum Allowance per year	1 per calendar year	1 pair per calendar year	
Pediatric Dental			
Carrier	Anthem Dental	Anthem Dental	
Network	Prime	Prime	
Deductible	Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded	
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	
Office Visit	100%	100%	
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	
Basic Services	50%	50%	
Major Services (no waiting period)	50%	50%	
Orthodontics (medically necessary)	50%	50%	

† HSA Qualified High Deductible Plan

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

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

2. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.

3. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.

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

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

6. Evaluation only.

7. Maximum member responsibility.

8. Medical emergency only.

9. Deductible applies depending on who is covered under the plan at the time service is rendered - Subscriber only: \$2,000 individual deductible; or Subscriber and Family coverage: \$2,700 individual and \$4,000 family deductible. For family deductible, for any given member, cost share applies either after he/she meets the per member deductible, or after the entire family deductible is met. The per family deductible can be met by any combination of amounts from any member, however no one member may contribute any more than his/her per member deductible toward the family deductible.

10. 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.

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

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

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

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



Silver EPO

Groups Beginning 4/1/19

Services	EPO A [†]	HSA Qualified	EPO B	EPO C
Participating Health Plans	Oscar		Oscar	Oscar
Network Name	Oscar EPO		Oscar EPO	Oscar EPO
Metal Tier	Silver		Silver	Silver
Calendar Year Deductible*	\$2,500 / \$2,700 / \$5,000 ³ (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)		\$2,000 / \$4,000 (combined Med/Pediatric dental ded)(applies to Max OOP)	\$1,500 / \$3,000 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,650 / \$13,300		\$7,550 / \$15,100	\$7,700 / \$15,400
Lifetime Maximum	Unlimited		Unlimited	Unlimited
Dr. Office Visits (PCP)	80%		\$45 Copay (ded waived)	\$50 Copay (ded waived)
Specialist Visit (SPC)	80%		\$80 Copay (ded waived)	\$75 Copay (ded waived)
Laboratory	80%		\$40 Copay (ded waived)	\$75 Copay (ded waived)
X-Ray	80% ⁸		\$75 Copay (ded waived) ⁸	\$75 Copay (ded waived) ⁸
MRI, CT and PET (office setting)	80% ⁸		\$300 Copay (ded waived) ⁸	50% ⁸
Hospital Services – In-Patient	80%		80%	50%
In-Patient Physician Fees	80%		80% (ded waived)	50%
Emergency Room (copay waived if admitted)	80%		\$350 Copay (ded waived)	\$500 Copay (ded waived)
Urgent Care	80%		\$45 Copay (ded waived)	\$75 Copay (ded waived)
Hospital Services – Out-Patient				
Surgical Facility	80%		80% (ded waived)	50%
Ambulatory Surgery Center	80%		80% (ded waived)	50%
Hospital Pre-Authorization	Required		Required	Required
2nd Surgical Opinion	80% ⁶		\$80 Copay (ded waived) ⁶	\$75 Copay (ded waived) ⁶
Ambulance Services (per trip)	80%		\$250 Copay	\$500 Copay (ded waived)
Rx Benefits				
Generic	80% (up to \$250 per prescription ⁴) (combined Med/Rx/Pediatric dental ded)		\$200 / \$400 Ded - \$15 Copay	\$25 Copay (ded waived)
Formulary Brand	80% (up to \$250 per prescription ⁴) (combined Med/Rx/Pediatric dental ded)		\$200 / \$400 Ded - \$55 Copay	\$50 Copay (ded waived)
Non-Formulary Brand	80% (up to \$250 per prescription ⁴) (combined Med/Rx/Pediatric dental ded)		\$200 / \$400 Ded - \$85 Copay	\$125 Copay (ded waived)
Specialty	80% (up to \$250 per prescription ⁴) (combined Med/Rx/Pediatric dental ded)		\$200 / \$400 Ded - 80% (up to \$250 per prescription ⁴)	50% (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100% (ded waived)		100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded/Rx Copay		Applicable Ded/Rx Copay	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered		Covered	Covered
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)		100% (ded waived) ¹	100% (ded waived) ¹
Chronic Disease Management	Covered as any Illness		Covered as any Illness	Covered as any Illness
Chemotherapy	80%		80% (ded waived)	50%
Chiropractic (20 visits max per year)	Not Covered		Not Covered	\$50 Copay (ded waived) ¹¹
Acupuncture	80%		\$45 Copay (ded waived)	\$50 Copay (ded waived)
Physical, Occupational, Speech Therapy	80%		\$45 Copay (ded waived)	\$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	80% ⁷		\$45 Copay (ded waived) ⁷	\$50 Copay (ded waived) ⁷

Services	EPO A [†]	HSA Qualified	EPO B	EPO C
Participating Health Plans	Oscar		Oscar	Oscar
Network Name	Oscar EPO		Oscar EPO	Oscar EPO
Metal Tier	Silver		Silver	Silver
Home Health Care (Max 100 visits per year)	80%		\$45 Copay (ded waived)	\$75 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%		80%	50%
Hospice (out-patient)	100%		100% (ded waived)	50%
Durable Medical Equipment (Covered when medically necessary)	80% ⁹		80% (ded waived) ⁹	50% ⁹
Mental Health				
In-Patient	80%		80%	50%
Out-Patient (office visit)	80%		\$45 Copay (ded waived)	\$50 Copay (ded waived)
Drug/Substance Abuse				
In-Patient (Detox Only)	80%		80%	50%
Infertility				
Infertility Evaluation and Treatment	See Plan Specific EOC ⁵		See Plan Specific EOC ⁵	See Plan Specific EOC ⁵
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	Oscar		Oscar	Oscar
Network	Davis Vision		Davis Vision	Davis Vision
Exam	100% (ded waived) ^{2, 10}		100% (ded waived) ^{2, 10}	\$75 Copay (ded waived) ^{2, 10}
Contact Lenses	100% (ded waived)(only in lieu of eyeglasses)		100% (ded waived)(only in lieu of eyeglasses)	50% (only in lieu of eyeglasses)
Frames	100% (ded waived)		100% (ded waived)	50%
Maximum Allowance per year	1 pair per calendar year		1 pair per calendar year	1 pair per calendar year
Pediatric Dental				
Carrier	Oscar		Oscar	Oscar
Network	Liberty		Liberty	Liberty
Deductible	Combined Med/Rx/Pediatric dental ded		Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical		Combined with Medical	Combined with Medical
Office Visit	Copay varies by service		Copay varies by service	Copay varies by service
Diagnostic & Preventative (D&P)	100% (ded waived) ²		100% (ded waived) ²	100% (ded waived) ²
Basic Services	Copay varies by service		Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service (prior auth. required)		Copay varies by service (prior auth. required)	Copay varies by service (prior auth. required)
Orthodontics (medically necessary)	50% (ded waived) (prior auth. required)		100% (prior auth. required)	50% (prior auth. required)

† HSA Qualified High Deductible Plan

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

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

2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.

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

4. Maximum member responsibility.

5. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.

6. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.

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

8. Prior-Authorization may be required.

9. Prior-Authorization required if annual cost is greater than \$500.

10. Limit one exam per 12 months.

11. No limit on the number of visits per year. Please see plan documents for more information.



Bronze HMO & HSP

Groups Beginning 4/1/19

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

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

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

- 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.
- Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.
- Pediatric dental and vision are included on all plans.
- See plan specific EOC for information on preventive services.
- The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
- Maximum member responsibility.
- 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.
- Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).
- Covered in full after out-of-pocket maximum is met.
- Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
- 1 pair of glasses or 1 pair of contact lenses per accumulation period.



Bronze HMO

Groups Beginning 4/1/19

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

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

[†] HSA Qualified High Deductible Plan

* 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.
- In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.

5. See plan specific EOC information on preventive services.

- 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.
- Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
- Maximum member responsibility.
- 1 pair of glasses or 1 pair of contact lenses per accumulation period.
- Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.



Bronze HMO

Groups Beginning 4/1/19

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

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

[†] HSA Qualified High Deductible Plan

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

1. Family deductibles (when applicable) and out-of-pocket maximums (OOPM) are "embedded". This means that an individual in a family plan is responsible for no more than the "individual family member" deductible and OOPM (please see exceptions below regarding high deductible health plans (HDHPs)). Once an individual family member has met their deductible, that family member will only be responsible for the specified copayment or coinsurance until that individual meets the individual family member OOPM or the family as a whole meets the family OOPM, whichever comes first. Deductibles and other cost sharing payments made by each individual in a family accrue to both the "family" deductible and "family" OOPM. Once the family deductible has been met, individual family members who have not yet met the individual family member OOPM amount will continue to be responsible for the specified copayment or coinsurance until they meet the individual family member OOPM or until the family as a whole meets the "family" OOPM, at which point, Sutter Health Plus pays all costs for covered services for all family members. For HDHPs, in a family plan, an individual family member's deductible must be the higher of the specified "single" deductible amount or the IRS minimum of \$2,700 for 2019 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.

2. Cost sharing for all essential health benefits, including that which accumulates toward an applicable deductible, accumulates toward the out-of-pocket maximum.

3. Copayments apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription for up to a 30-day supply. For HDHP plans, this \$200 maximum will not apply until after the deductible is met.

4. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.

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

6. Pediatric eye exam and glasses or contact lenses are provided annually for members through the end of the month in which the member turns 19 years of age as part of the essential health benefit for pediatric vision.

7. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.

8. When outpatient benefits have Cost Sharing that includes "deductible waived for 1st 3 non-preventive visits", the Deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient MH/SUD visits.

9. Other practitioner office visits includes therapy visits, and other office visits not provided by either primary care physicians or specialists or visits not specified in another benefit category.

10. In a high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum work differently. In a Self-Only coverage plan, you must meet the Self-Only Deductible and the Self-Only Out-of-Pocket Maximum. Once you meet the Self-Only Deductible, Sharp Health Plan will pay for your services. The Self-Only Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In a Family plan, each individual in the family must meet the Individual Deductible until the Family Deductible is met. Once an individual meets the Individual Deductible, Sharp Health Plan will pay for services for that individual in the family. Once the Family Deductible is met, Sharp Health Plan will pay for services for the entire family. All family members have met the Family Out-of-Pocket Maximum when the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum.

(Footnotes continued on page 34)



Bronze HMO

Groups Beginning 4/1/19

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

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

† HSA Qualified High Deductible Plan

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

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

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

3. Family deductibles (when applicable) and out-of-pocket maximums (OOPM) are "embedded". This means that an individual in a family plan is responsible for no more than the "individual family member" deductible and OOPM (please see exceptions below regarding high deductible health plans (HDHPs)). Once an individual family member has met their deductible, that family member will only be responsible for the specified copayment or coinsurance until that individual meets the individual family member OOPM or the family as a whole meets the family OOPM, whichever comes first. Deductibles and other cost sharing payments made by each individual in a family accrue to both the "family" deductible and "family" OOPM. Once the family deductible has been met, individual family members who have not yet met the individual family member OOPM amount will continue to be responsible for the specified copayment or coinsurance until they meet the individual family member OOPM or until the family as a whole meets the "family" OOPM, at which point, Sutter Health Plus pays all costs for covered services for all family members. For HDHPs, in a family plan, an individual family member's deductible must be the higher of the specified "single" deductible amount or the IRS minimum of \$2,700 for 2019 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.

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

5. Cost sharing for all essential health benefits, including that which accumulates toward an applicable deductible, accumulates toward the out-of-pocket maximum.

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

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

8. Maximum member responsibility.

9. Copayments apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription for up to a 30-day supply. For HDHP plans, this \$200 maximum will not apply until after the deductible is met.

(Footnotes continued on page 34)



Bronze HMO

Groups Beginning 4/1/19

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

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

† HSA Qualified High Deductible Plan

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

- Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
- The annual out-of-pocket maximum is the total amount 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.
- The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.

8. Maximum member responsibility.

9. Deductible waived for first three non-preventive care visits.

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

11. Covered in full after out-of-pocket maximum is met.

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

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



Bronze EPO

Groups Beginning 4/1/19

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

Services	EPO A	EPO A†	HSA Qualified	EPO B
Participating Health Plans	Anthem Blue Cross	Oscar		Oscar
Network Name	Prudent Buyer – Small Group	Oscar EPO		Oscar EPO
Metal Tier	Bronze	Bronze		Bronze
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) ⁵	100%		100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% ¹³	100%		100%
Hospice (out-patient)	100%	100%		100%
Durable Medical Equipment (Covered when medically necessary)	50%	100% ²⁰		100% ²⁰
Mental Health				
In-Patient	60%	100%		100%
Out-Patient (office visit)	60%	100%		100%
Drug/Substance Abuse				
In-Patient (Detox Only)	60%	100%		100%
Infertility				
Infertility Evaluation and Treatment	\$65 Copay (first 3 visits) ⁸ – \$65 Copay ⁷	See Plan Specific EOC ¹⁷		See Plan Specific EOC ¹⁷
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	Anthem Vision	Oscar		Oscar
Network	Blue View Vision	Davis Vision		Davis Vision
Exam	100% (ded waived)	100% ^{15, 21}		100% ^{15, 21}
Contact Lenses	1 pair per calendar year	100% (only in lieu of eyeglasses)		100% (only in lieu of eyeglasses)
Frames	1 pair per calendar year (ded waived)	100%		100%
Maximum Allowance per year	1 per calendar year	1 pair per calendar year		1 pair per calendar year
Pediatric Dental				
Carrier	Anthem Dental	Oscar		Oscar
Network	Prime	Liberty		Liberty
Deductible	Combined Med/Rx/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded		Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical		Combined with Medical
Office Visit	100%	Copay varies by service		Copay varies by service
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived) ¹⁵		100% (ded waived) ¹⁵
Basic Services	50%	Copay varies by service		Copay varies by service
Major Services (no waiting period)	50%	Copay varies by service (prior auth. required)		Copay varies by service (prior auth. required)
Orthodontics (medically necessary)	50%	100% (prior auth. required)		100% (prior auth. required)

† HSA Qualified High Deductible Plan

* 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.
- 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.
- Maximum member responsibility.
- Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
- Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.
- See plan specific EOC for information on preventive services.
- Evaluation only.
- Office visits are per Member and combined for primary care physician, specialist, other provider, Counseling (including Family Planning, Nutritional), and Telehealth. These Office Visits have a Copayment with deductible waived for in-network providers which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and then a Copayment. Always check the setting above to determining your payment

responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.

- 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.
- Medical emergency only.
- 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.
- Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
- Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.

(Footnotes continued on page 34)



Additional Footnotes

Groups Beginning 4/1/19

Silver HMO

(Footnotes continued from page 9)

13. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.
14. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum
15. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
16. The pediatric dental out-of-pocket maximum is \$350 for a family with one child and \$700 for a family with 2 or more children.
17. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.

Bronze HMO

(Footnotes continued from page 27)

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

Bronze HMO

(Footnotes continued from page 29)

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

Silver PPO

(Footnotes continued from page 17)

- * All services are subject to the deductible unless otherwise stated. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; 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.

Bronze EPO

(Footnotes continued from page 33)

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

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