Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 7/1/20

CaliforniaChoice®
Your Health. Your Choice.®

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

CONTENTS

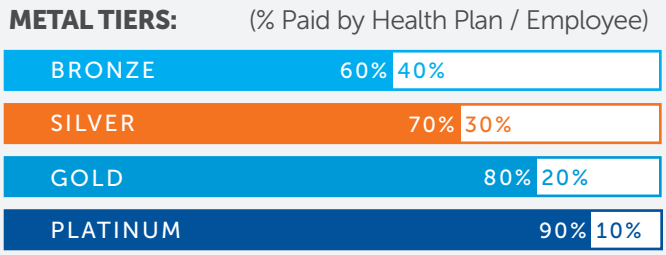
The benefits listed in this brochure were collected from all plans participating in the CaliforniaChoice® *Program and are accurate to the best of our knowledge at the time of print. If the information in this brochure differs from the information in the SBC (Summary of Benefits and Coverage), EOC (Evidence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

TRUSTED BY CALIFORNIANS FOR OVER 20 YEARS.

When we started CaliforniaChoice® in 1996, the idea of offering a program that provided small businesses and their employees access to multiple health insurance carriers and benefits was truly revolutionary. Today, we're pleased to offer eight health plans and more than 80 PPO, HMO, EPO, and HSA plan design options.

GREATER ACCESS TO DOCTORS, SPECIALISTS, AND HOSPITALS

CaliforniaChoice offers health plans in all of the Affordable Care Act's (ACA) four metal tiers: Bronze, Silver, Gold, and Platinum. Each tier offers a different percentage of shared health care costs for the employee, ranging from 10% to 40% (with the health plan paying the other 90% to 60%), as shown to the right. This can significantly increase the number of plans, doctors, and specialists available to your employees.



Please keep in mind that some plans may pay a different percentage of health care costs than what is shown above for each tier; refer to each plan's summary of benefits for specific covered percentage details.

1. CHOOSE YOUR METAL TIER(S)

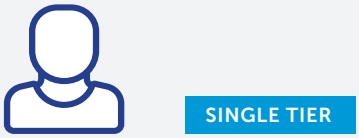
Three tiers, two or one. Give your employees access to three options when it comes to ACA metal tiers:

Offer more choices! Employees have access to health plans and benefits available in **three neighboring tiers**.

- NEW: Bronze, Silver, Gold
- Silver, Gold, Platinum

Offer employees access to the health plans and benefits available in **two neighboring tiers**.

- Bronze, Silver
- Silver, Gold
- Gold, Platinum



Offer employees access to the health plans and benefits available in a **single tier**.

- Bronze
- Silver
- Gold
- Platinum

2. Define Your Monthly Contribution

Your broker will share plan premium information with you. Select your preferred plan and whether you want to pay a **Fixed Percentage** of costs (select from 50% to 100%) or a **Fixed Dollar Amount** toward that plan.

3. Employees Select Their Benefits

After you select your metal tier(s) and define your contribution, each employee is provided with a personalized worksheet that spells out all options available, and the specific costs involved. Your employees also have access to other tools at calchoice.com that make it easy to determine which plans best meet their needs.

*On the following pages you'll find a summary of the benefits offered in each tier level. For more information, please contact your broker or visit **calchoice.com**.*

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO C	HMO D
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	WholeCare	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,200 / $4,400 [9]	$2,250 / $4,500	$2,250 / $4,500 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$15 Copay	$30 Copay	$30 Copay
Specialist Visit (SPC)	$30 Copay	$50 Copay	$50 Copay
Laboratory	$15 Copay [18]	$20 Copay	$20 Copay
X-Ray	$25 Copay [18]	$50 Copay	$50 Copay
MRI, CT and PET (office setting)	$100 Copay per test [20]	$250 Copay per procedure	$250 Copay per procedure
Hospital Services – In-Patient	$250 Copay per day – 3 days max per admit	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$200 Copay	$250 Copay	$250 Copay
Urgent Care	$15 Copay	$30 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay $200 Copay	 $150 Copay $150 Copay [2]	 $150 Copay $150 Copay [2]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$30 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$150 Copay [15]	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [16] $35 Copay [16] $70 Copay [16] 70% (up to $250 per prescription [14]) (prior auth. required) [12, 16]	 $5 Copay [6, 7] $20 Copay [6, 7] $30 Copay [6, 7] 70% (up to $250 per prescription [14]) (prior auth. required) [6, 7]	 $5 Copay [6, 7] $20 Copay [6, 7] $30 Copay [6, 7] 70% (up to $250 per prescription [14]) (prior auth. required) [6, 7]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [16]	Applicable Rx Copay [6,7]	Applicable Rx Copay [6, 7]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	$50 Copay	$50 Copay
Chemotherapy	$30 Copay	100%	100%
Chiropractic (20 visits max per year)	$15 Copay (20 visits max per benefit period) [17]	Not Covered	Not Covered
Acupuncture	$15 Copay	$10 Copay [1]	$10 Copay [1]
Physical, Occupational, Speech Therapy	$15 Copay [18]	$30 Copay [18]	$30 Copay [18]
Rehabilitative & Habilitative Services and Devices	$15 Copay [18]	$30 Copay [18]	$30 Copay [18]
Home Health Care (Max 100 visits per year)	$30 Copay (Max 100 visits per benefit period) [11]	$30 Copay	$30 Copay

Services	HMO A	HMO C	HMO D
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	Select HMO	WholeCare	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$100 Copay per day – 3 days max per admit [19]	$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)	$100 Copay	70%	70%
Mental Health In-Patient Out-Patient (office visit)	 $250 Copay per day – 3 days max per admit $15 Copay	 $500 Copay per day – 4 days max [5] $30 Copay [5]	 $500 Copay per day – 4 days max [5] $30 Copay [5]
Drug/Substance Abuse In-Patient (Detox Only)	 $250 Copay per day – 3 days max per admit	 $500 Copay per day – 4 days max	 $500 Copay per day – 4 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $15 Copay [13] 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	 Anthem Vision Blue View Vision 100% 100% (in lieu of eyeglasses) 100% 1 per calendar year	 EyeMed [10] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [10] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime None Combined with Medical 100% 100% 50% 50% 50%	 Dental Benefit Providers [8, 10] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 10] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. Must be medically necessary.
2. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types..
3. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
4. See plan specific EOC for information on preventive services.
5. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
6. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. 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.
10. Pediatric dental and vision are included on all plans.
11. Limited to 100 4-hour visits per benefit period.
12. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
13. Evaluation only.
14. Maximum member responsibility.
15. Medical emergency only.
16. The four prescription drug tiers are: tier 1 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.
17. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
18. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
19. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
20. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Platinum HMO

Groups Beginning 7/1/20

Services	HMO E	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,250 / $4,500	$3,000 / $6,000 [17]	$4,500 / $9,000 [17]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$10 Copay	$15 Copay
Specialist Visit (SPC)	$50 Copay	$20 Copay	$30 Copay
Laboratory	$20 Copay	$20 Copay	$15 Copay
X-Ray	$50 Copay	$40 Copay	$30 Copay
MRI, CT and PET (office setting)	$250 Copay per procedure	$150 Copay per procedure	$75 Copay per procedure
Hospital Services – In-Patient	$500 Copay per day – 4 days max	$500 Copay per admit	$250 Copay per day – 5 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$200 Copay	$150 Copay
Urgent Care	$30 Copay	$10 Copay	$15 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $150 Copay $150 Copay [8]	 $300 Copay per procedure $300 Copay per procedure	 $125 Copay per procedure $125 Copay per procedure
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$20 Copay	$30 Copay
Ambulance Services (per trip)	$100 Copay	$150 Copay	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay [12, 13] $20 Copay [12, 13] $30 Copay [12, 13] 70% (up to $250 per prescription [9]) (prior auth. required) [12, 13]	 $5 Copay $15 Copay $15 Copay (with physician approval) 90% (up to $250 per prescription [9]) (with physician approval)	 $5 Copay $15 Copay $15 Copay (with physician approval) 90% (up to $250 per prescription [9]) (with physician approval)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [12, 13]	$15 Copay	$15 Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [5]	100% [5]	100% [5]
Chronic Disease Management	$50 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	100%	90%
Chiropractic (20 visits max per year)	Not Covered	$15 Copay [10]	Not Covered
Acupuncture	$10 Copay [15]	$10 Copay [10]	$15 Copay
Physical, Occupational, Speech Therapy	$30 Copay [14]	$10 Copay	$15 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay [14]	$10 Copay	$15 Copay
Home Health Care (Max 100 visits per year)	$30 Copay	100% [1]	$20 Copay [1]

Services	HMO E	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$250 Copay per admit	$150 Copay per day – 5 days max
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	90% [6]	90% [6]
Mental Health In-Patient Out-Patient (office visit)	 $500 Copay per day – 4 days max [16] $30 Copay [16]	 $500 Copay per admit $10 Copay	 $250 Copay per day – 5 days max $15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $500 Copay per day – 4 days max	 $500 Copay per admit	 $250 Copay per day – 5 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [19] EyeMed 100% 100% 1 pair per calendar year None	 Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year [11] 1 pair per calendar year [11] None	 Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year [11] 1 pair per calendar year [11] None
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 [4, 7] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [2] $365 Copay [3] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [2] $365 Copay [3] $350 Copay

* 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. 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.
5. See plan specific EOC for information on preventive services.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. Pediatric dental and vision are included on all plans.
8. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types
9. Maximum member responsibility.
10. 20 visits max per year combined for Chiropractic and Acupuncture.
11. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
12. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
13. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
14. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
15. Must be medically necessary.
16. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
17. 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.

Platinum HMO

Groups Beginning 7/1/20

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

Services	HMO A	HMO B
Participating Health Plans	Sharp	Sharp
Network Name	Premier	Performance
Metal Tier	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay	85%
Hospice (out-patient)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $400 Copay $15 Copay	 85% $15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $400 Copay	 85%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
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
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [5] 100% 100% $25 Copay [1] $350 Copay [2] $350 Copay	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [5] 100% 100% $25 Copay [1] $350 Copay [2] $350 Copay

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

1. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
2. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Amount listed for In-Patient Services only.

Platinum HMO

Groups Beginning 7/1/20

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [11]	$4,500 / $9,000 [1]	$3,500 / $7,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$10 Copay	$15 Copay [7]	$25 Copay [7]
Specialist Visit (SPC)	$20 Copay	$30 Copay	$25 Copay
Laboratory	$10 Copay	$15 Copay	$25 Copay
X-Ray	$40 Copay	$30 Copay per procedure	$25 Copay per procedure
MRI, CT and PET (office setting)	$150 Copay per procedure	$75 Copay per procedure	$150 Copay per procedure
Hospital Services – In-Patient	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit	$250 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$200 Copay	$150 Copay	$100 Copay
Urgent Care	$20 Copay	$15 Copay	$25 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 $100 Copay $100 Copay	 90% 90%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$20 Copay	$30 Copay	$25 Copay
Ambulance Services (per trip)	$200 Copay	$150 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $25 Copay $50 Copay Applicable Rx Copay	 $5 Copay [2] $15 Copay [2, 3] $25 Copay [2, 3] 90% (up to $250 per prescription [8]) [2, 3]	 $5 Copay [2] $15 Copay [2, 3] $25 Copay [2, 3] 90% (up to $250 per prescription [8]) [2, 3]
Oral Contraceptives	100% (if in formulary)	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay [2, 3]	Applicable Rx Copay [2, 3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	$350 Copay per day – 5 days max [15]	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	$20 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [10]	90%	90%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay	$15 Copay	$25 Copay
Physical, Occupational, Speech Therapy	$10 Copay	$15 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$10 Copay	$15 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$10 Copay	$20 Copay	$25 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay	$150 Copay per day – 5 days max per admit	90%

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	90%	90%
Mental Health In-Patient Out-Patient (office visit)	 $200 Copay per day – 5 days max $10 Copay	 $250 Copay per day – 5 days max per admit [9] $15 Copay	 $250 Copay per day – 5 days max per admit [9] $25 Copay
Drug/Substance Abuse In-Patient (Detox Only)	$200 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit [9]	$250 Copay per day – 5 days max per admit [9]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% [5] 100% (in lieu of eyeglasses) [5, 6] 100% (in lieu of contact lenses) [5, 6] 1 pair per year	 VSP Choice Network 100% [5] 100% (in lieu of eyeglasses) [5, 6] 100% (in lieu of contact lenses) [5, 6] 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [12] 100% 100% $25 Copay [13] $350 Copay [14] $350 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% Copay varies by service Copay varies by service $1,000 Copay

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

1. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
2. Cost sharing applies 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 retail 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 $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
3. 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.
4. See plan specific EOC for information on preventive services.
5. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
6. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
7. 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.
8. Maximum member responsibility.
9. 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.
10. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
11. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum
12. 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.
13. 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.
14. 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.
15. Amount listed for In-Patient Services only

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Focus	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,500 / $7,000 [2]	$3,500 / $7,000 [2]	$3,500 / $7,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$20 Copay
Specialist Visit (SPC)	$40 Copay	$40 Copay	$40 Copay
Laboratory	$25 Copay	$25 Copay	$25 Copay
X-Ray	$25 Copay	$25 Copay	$25 Copay
MRI, CT and PET (office setting)	$200 Copay per procedure	$200 Copay per procedure	$200 Copay per procedure
Hospital Services – In-Patient	80%	80%	80%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	80%	80%	80%
Urgent Care	$50 Copay	$50 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 80% 80%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$40 Copay	$40 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [5]) [3]	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [5]) [3]	 $15 Copay $35 Copay [3] $70 Copay [3] 75% (up to $250 per prescription [5]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [3]	Applicable Rx Copay [3]	Applicable Rx Copay [3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [1]	100% [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [4]	$150 Copay [4]	$150 Copay [4]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$20 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$20 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$20 Copay	$20 Copay

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Focus	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%	80%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$50 Copay	$50 Copay	$50 Copay
Mental Health In-Patient Out-Patient (office visit)	 80% $20 Copay	 80% $20 Copay	 80% $20 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 80%	 80%
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% 80% 80% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 80% 80% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 80% 80% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. For Specialty drugs, please see plan specific EOC.
4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Maximum member responsibility.

Platinum HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$4,500 / $9,000 [1]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$15 Copay
Specialist Visit (SPC)	$25 Copay	$30 Copay
Laboratory	100%	$15 Copay
X-Ray	100%	$30 Copay
MRI, CT and PET (office setting)	$100 Copay	$75 Copay
Hospital Services – In-Patient	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	$150 Copay	$150 Copay
Urgent Care	$50 Copay	$15 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 $100 Copay $100 Copay
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$25 Copay	$40 Copay
Ambulance Services (per trip)	100%	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $30 Copay [9] $50 Copay [9] 80% (up to $250 per 30 day supply [6]) [3]	 $5 Copay $15 Copay [9] $25 Copay [9] 90% (up to $250 per 30 day supply [6]) [3]
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	$30 Copay	$15 Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [2, 5]	100% [2, 5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	90% [3]
Chiropractic (20 visits max per year)	$15 Copay [8]	$15 Copay [8]
Acupuncture	$15 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$15 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$15 Copay
Home Health Care (Max 100 visits per year)	100%	$20 Copay

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

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

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

Platinum EPO

Groups Beginning 7/1/20

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Out-of-Pocket Max Ind/Fam	$4,500 / $9,000	$2,500 / $5,000
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$15 Copay	$30 Copay
Specialist Visit (SPC)	$30 Copay	$50 Copay
Laboratory	$15 Copay	$30 Copay
X-Ray	$30 Copay[7]	$50 Copay[7]
MRI, CT and PET (office setting)	$75 Copay[7]	$50 Copay[7]
Hospital Services – In-Patient	$250 Copay per day – 5 days max per admit	$500 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	$50 Copay
Emergency Room (copay waived if admitted)	$150 Copay	$250 Copay
Urgent Care	$15 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 $150 Copay $150 Copay
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$30 Copay[4]	$50 Copay[4]
Ambulance Services (per trip)	$150 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay $15 Copay $25 Copay 90% (up to $250 per prescription[6])	 $5 Copay $15 Copay $25 Copay 70% (up to $250 per prescription[6])
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100%[1]	100%[1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	90%	70%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	$15 Copay	$30 Copay
Physical, Occupational, Speech Therapy	$15 Copay	$30 Copay
Rehabilitative & Habilitative Services and Devices	$15 Copay[5]	$30 Copay[5]
Home Health Care (Max 100 visits per year)	$20 Copay (Max 100 visits per benefit period)	$50 Copay (Max 100 visits per benefit period)

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 5 days max per admit	$500 Copay per day – 5 days max per admit
Hospice (out-patient)	100%	$500 Copay
Durable Medical Equipment (Covered when medically necessary)	90% [8]	70% [8]
Mental Health In-Patient Out-Patient (office visit)	 $250 Copay per day – 5 days max per admit $15 Copay	 $500 Copay per day – 5 days max per admit $30 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $250 Copay per day – 5 days max per admit	 $500 Copay per day – 5 days max per admit
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Covered for Evaluation Only [3] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [3] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vison 100% [2, 9] 100% (only in lieu of eyeglasses) 100% 1 pair per calendar year	 Oscar Davis Vision $50 Copay [2, 9] 70% (only in lieu of eyeglasses) 70% 1 pair 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)	 Oscar Liberty None Combined with Medical Copay varies by service 100% [2] Copay varies by service Copay varies by service (prior auth. required) $1,000 Copay (prior auth. required)	 Oscar Liberty None Combined with Medical Copay varies by service 100% [2] Copay varies by service Copay Varies by service (prior auth. required) 100% (prior auth. required)

* *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. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
4. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
5. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
6. Maximum member responsibility.
7. Prior-Authorization may be required.
8. Prior-Authorization required if annual cost is greater than $500.
9. Limit one exam per 12 months.

Gold HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible *	None	None	None
Out-of-Pocket Max Ind/Fam	$5,800 / $11,600 [4]	$5,800 / $11,600 [4]	$7,000 / $14,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$30 Copay	$30 Copay
Specialist Visit (SPC)	$55 Copay	$55 Copay	$45 Copay
Laboratory	$25 Copay [7]	$25 Copay [7]	$40 Copay
X-Ray	$40 Copay [7]	$40 Copay [7]	$50 Copay
MRI, CT and PET (office setting)	$100 Copay per test [12]	$100 Copay per test [12]	$250 Copay per procedure
Hospital Services – In-Patient	$500 Copay per day – 4 days max per admit	$500 Copay per day – 4 days max per admit	$500 Copay per day – 3 days max
In-Patient Physician Fees	100%	100%	60%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$250 Copay
Urgent Care	$30 Copay	$30 Copay	$45 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $500 Copay	 $500 Copay $500 Copay	 60% 60% [13]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$55 Copay	$45 Copay
Ambulance Services (per trip)	$150 Copay [1]	$150 Copay [1]	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [2] $40 Copay [2] $80 Copay [2] 70% (up to $250 per prescription [10]) (prior auth. required) [2, 8]	 $15 Copay [2] $40 Copay [2] $80 Copay [2] 70% (up to $250 per prescription [10]) (prior auth. required) [2, 8]	 $10 Copay [14, 15] $50 Copay [14, 15] $60 Copay [14, 15] 60% (up to $250 per prescription [10]) (prior auth. required) [14, 15]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [2]	Applicable Rx Copay [2]	Applicable Rx Copay [14, 15]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3]	100% [3]	100% [3]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	$45 Copay
Chemotherapy	$55 Copay	$55 Copay	100%
Chiropractic (20 visits max per year)	$30 Copay (20 visits max per benefit period) [6]	$30 Copay (20 visits max per benefit period) [6]	Not Covered
Acupuncture	$30 Copay	$30 Copay	$10 Copay [16]
Physical, Occupational, Speech Therapy	$30 Copay [7]	$30 Copay [7]	$30 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay [7]	$30 Copay [7]	$30 Copay
Home Health Care (Max 100 visits per year)	$55 Copay (Max 100 visits per benefit period) [5]	$55 Copay (Max 100 visits per benefit period) [5]	$30 Copay

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 4 days max per admit [11]	$150 Copay per day – 4 days max per admit [11]	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$100 Copay	$100 Copay	60%
Mental Health In-Patient Out-Patient (office visit)	 $500 Copay per day – 4 days max per admit $30 Copay	 $500 Copay per day – 4 days max per admit $30 Copay	 $500 Copay per day – 3 days max [17] $30 Copay [17]
Drug/Substance Abuse In-Patient (Detox Only)	 $500 Copay per day – 4 days max per admit	 $500 Copay per day – 4 days max per admit	 $500 Copay per day – 3 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $30 Copay [9] Not Covered Not Covered Not Covered Not Covered	 $30 Copay [9] 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	 Anthem Vision Blue View Vision 100% 100% (in lieu of eyeglasses) 100% 1 per calendar year	 Anthem Vision Blue View Vision 100% 100% (in lieu of eyeglasses) 100% 1 per calendar year	 EyeMed [18] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime None Combined with Medical 100% 100% 50% 50% 50%	 Anthem Dental Prime None Combined with Medical 100% 100% 50% 50% 50%	 Dental Benefit Providers [18, 19] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. Medical emergency only.
2. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
5. Limited to 100 4-hour visits per benefit period.
6. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
9. Evaluation only.
10. Maximum member responsibility.
11. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
12. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
13. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
14. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
15. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
16. Must be medically necessary.
17. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
18. Pediatric dental and vision are included on all plans.
19. 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.

Gold HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C	HMO D
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	Salud HMO y Mas
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000	$6,000 / $12,000	$6,000 / $12,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay	$35 Copay	$35 Copay
Specialist Visit (SPC)	$60 Copay	$55 Copay	$55 Copay
Laboratory	$40 Copay	$40 Copay	$40 Copay
X-Ray	$50 Copay	$50 Copay	$50 Copay
MRI, CT and PET (office setting)	$300 Copay per procedure	$300 Copay per procedure	$300 Copay per procedure
Hospital Services – In-Patient	$1,000 Copay	$750 Copay per day – 3 days max	$750 Copay per day – 3 days max
In-Patient Physician Fees	60%	100%	100%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$300 Copay
Urgent Care	$60 Copay	$55 Copay	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60% [11]	 $1,200 Copay $480 Copay [11]	 $1,200 Copay $480 Copay [11]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay	$55 Copay	$55 Copay
Ambulance Services (per trip)	$300 Copay	$300 Copay	$300 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 60% (up to $250 per prescription [10]) (prior auth. required) [5, 7]	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 70% (up to $250 per prescription [10]) (prior auth. required) [5, 7]	 $15 Copay [5, 7] $50 Copay [5, 7] $70 Copay [5, 7] 70% (up to $250 per prescription [10]) (prior auth. required) [5, 7]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [5, 7]	Applicable Rx Copay [5, 7]	Applicable Rx Copay [5, 7]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3]	100% [3]	100% [3]
Chronic Disease Management	$60 Copay	$55 Copay	$55 Copay
Chemotherapy	100%	100%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay [1]	$10 Copay [1]	$10 Copay [1]
Physical, Occupational, Speech Therapy	$45 Copay	$35 Copay [6]	$35 Copay [6]
Rehabilitative & Habilitative Services and Devices	$45 Copay	$35 Copay [6]	$35 Copay [6]
Home Health Care (Max 100 visits per year)	$45 Copay	$35 Copay	$35 Copay

Services	HMO B	HMO C	HMO D
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	Salud HMO y Mas
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	60%	70%	70%
Mental Health In-Patient Out-Patient (office visit)	 $1,000 Copay [4] $45 Copay [4]	 $750 Copay per day – 3 days max [4] $35 Copay [4]	 $750 Copay per day – 3 days max [4] $35 Copay [4]
Drug/Substance Abuse In-Patient (Detox Only)	 $1,000 Copay	 $750 Copay per day – 3 days max	 $750 Copay per day – 3 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. Must be medically necessary.
2. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
3. See plan specific EOC for information on preventive services.
4. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
5. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
6. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Pediatric dental and vision are included on all plans.
10. Maximum member responsibility.
11. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.

Gold HMO

Groups Beginning 7/1/20

Services	HMO E	HMO F	HMO A
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$500 / $1,000 [6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000	$7,000 / $14,000	$7,000 / $14,000 [7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$45 Copay	$30 Copay (ded waived)
Specialist Visit (SPC)	$55 Copay	$60 Copay	$35 Copay (ded waived)
Laboratory	$40 Copay	$40 Copay	$20 Copay (ded waived)
X-Ray	$50 Copay	$50 Copay	$40 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay per procedure	$300 Copay per procedure	$300 Copay per procedure
Hospital Services – In-Patient	$750 Copay per day – 3 days max	$1,000 Copay	$600 Copay per day – 5 days max
In-Patient Physician Fees	100%	60%	100%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$250 Copay
Urgent Care	$55 Copay	$60 Copay	$30 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $1,200 Copay $480 Copay [9]	 60% 60% [9]	 $600 Copay per procedure $600 Copay per procedure
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$60 Copay	$35 Copay (ded waived)
Ambulance Services (per trip)	$300 Copay	$300 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [14, 16] $50 Copay [14, 16] $70 Copay [14, 16] 70% (up to $250 per prescription [11]) (prior auth. required) [14, 16]	 $15 Copay [14, 16] $50 Copay [14, 16] $70 Copay [14, 16] 60% (up to $250 per prescription [11]) (prior auth. required) [14, 16]	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) $50 Copay (overall ded waived) (with physician approval) 80% (up to $250 per prescription [11]) (overall ded waived) (with physician approval)
Oral Contraceptives	100%	100%	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay [14, 16]	Applicable Rx Copay [14, 16]	$50 Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [5]	100% [5]	100% (ded waived) [5]
Chronic Disease Management	$55 Copay	$60 Copay	Covered as any Illness
Chemotherapy	100%	100%	100% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	$15 Copay (ded waived) [12]
Acupuncture	$10 Copay [4]	$10 Copay [4]	$30 Copay (ded waived) [12]
Physical, Occupational, Speech Therapy	$35 Copay [15]	$45 Copay [15]	$30 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$35 Copay [15]	$45 Copay [15]	$30 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$35 Copay	$45 Copay	100% (ded waived) [1]

Services	HMO E	HMO F	HMO A
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$300 Copay per day – 5 days max
Hospice (out-patient)	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	70%	60%	80% (ded waived) [8]
Mental Health In-Patient Out-Patient (office visit)	 $750 Copay per day – 3 days max [10] $35 Copay [10]	 $1,000 Copay [10] $45 Copay [10]	 $600 Copay per day – 5 days max $30 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 $750 Copay per day – 3 days max	 $1,000 Copay	 $600 Copay per day – 5 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [18] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [18] EyeMed 100% 100% 1 pair per calendar year None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [13] 1 pair per calendar year (ded waived) [13] 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 [17, 18] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Dental Benefit Providers [17, 18] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $40 Copay [2] $365 Copay [3] $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. Must be medically necessary.
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. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
10. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
11. Maximum member responsibility.
12. 20 visits max per year combined for Chiropractic and Acupuncture.
13. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
14. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
15. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
16. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
17. 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.
18. Pediatric dental and vision are included on all plans.

Gold HMO

Groups Beginning 7/1/20

Services	HMO B	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Performance	Premier
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$250 / $500 [12] (applies to Max OOP)	None	None
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [9]	$8,000 / $16,000 [3]	$8,000 / $16,000 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay (ded waived)	$20 Copay	$25 Copay
Specialist Visit (SPC)	$50 Copay (ded waived)	$50 Copay	$55 Copay
Laboratory	$25 Copay (ded waived)	$15 Copay	$15 Copay
X-Ray	$65 Copay (ded waived)	$20 Copay	$55 Copay
MRI, CT and PET (office setting)	$275 Copay per procedure (ded waived)	$175 Copay per procedure	$175 Copay per procedure
Hospital Services – In-Patient	$600 Copay per day – 5 days max	70%	$600 Copay per day – 5 days max
In-Patient Physician Fees	100% (ded waived)	70%	100%
Emergency Room (copay waived if admitted)	$250 Copay	70%	$300 Copay
Urgent Care	$25 Copay (ded waived)	$50 Copay	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $340 Copay per procedure (ded waived) $340 Copay per procedure (ded waived)	 70% 70%	 75% 75%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay (ded waived)	$50 Copay	$55 Copay
Ambulance Services (per trip)	$250 Copay	70%	$200 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) $50 Copay (overall ded waived) (with physician approval) 80% (up to $250 per prescription [11])(overall ded waived) (with physician approval)	 $19 Copay (ded waived) $150 / $300 Ded – $35 Copay $150 / $300 Ded – $70 Copay $150 / $300 Ded – Applicable Rx Copay	 $19 Copay (ded waived) $300 / $600 Ded – $40 Copay $300 / $600 Ded – $75 Copay $300 / $600 Ded – Applicable Rx Copay
Oral Contraceptives	100% (ded waived)	100% (if in formulary)	100% (if in formulary)
Diabetes – Self-Injectable	$50 Copay (overall ded waived)	$150 / $300 Ded – Applicable Rx Copay	$300 / $600 Ded – Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	70% [10]	$600 Copay per day – 5 days max [10]
Preventive/Wellness Services	100% (ded waived) [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	$50 Copay	$55 Copay
Chemotherapy	80% (ded waived)	Variable [6]	Variable [6]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$25 Copay (ded waived)	$20 Copay	$25 Copay
Physical, Occupational, Speech Therapy	$25 Copay (ded waived)	$20 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay (ded waived)	$20 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$30 Copay (ded waived) [7]	$20 Copay	$25 Copay

Services	HMO B	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Performance	Premier
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max	70%	$25 Copay per day
Hospice (out-patient)	100% (ded waived)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) [8]	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $600 Copay per day – 5 days max $25 Copay (ded waived)	 70% $20 Copay	 $200 Copay per day – 5 days max $25 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $600 Copay per day – 5 days max	 70%	 $200 Copay per day – 5 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [13] 1 pair per calendar year (ded waived) [13] None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $40 Copay [1] $365 Copay [2] $350 Copay	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [5] 100% 100% $25 Copay [1] $350 Copay [2] $350 Copay	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [5] 100% 100% $25 Copay [1] $350 Copay [2] $350 Copay

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

1. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
2. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. 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).
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. 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..
10. Amount listed for In-Patient Services only.
11. Maximum member responsibility.
12. 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.
13. 1 pair of glasses or 1 pair of contact lenses per accumulation period.

Gold HMO

Groups Beginning 7/1/20

Services	HMO D	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$1,500 / $3,000[14] (applies to Max OOP)	$250 / $500[14] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500/ $13,000[4]	$3,000 / $6,000[6]	$7,800 / $15,600[6]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay	$30 Copay[7]	$25 Copay (ded waived)[7]
Specialist Visit (SPC)	$55 Copay	$50 Copay	$50 Copay (ded waived)
Laboratory	$15 Copay	$30 Copay	$25 Copay (ded waived)
X-Ray	$55 Copay	$30 Copay per procedure	$65 Copay per procedure (ded waived)
MRI, CT and PET (office setting)	$175 Copay per procedure	$50 Copay per procedure	$275 Copay per procedure (ded waived)
Hospital Services – In-Patient	$1,500 Copay	80%	$600 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	80%	100% (ded waived)
Emergency Room (copay waived if admitted)	$300 Copay	$150 Copay	$250 Copay
Urgent Care	$55 Copay	$30 Copay	$25 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $600 Copay per procedure $600 Copay per procedure	 80% 80%	 $300 Copay (ded waived) $300 Copay (ded waived)
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$50 Copay	$50 Copay (ded waived)
Ambulance Services (per trip)	$200 Copay	$150 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $19 Copay $35 Copay $70 Copay Applicable Rx Copay	 $5 Copay (overall ded waived)[8] $15 Copay (overall ded waived)[8, 9] $25 Copay (overall ded waived)[8, 9] 80% (up to $250 per prescription[5]) (overall ded waived)[8, 9]	 $15 Copay (overall ded waived)[8] $50 Copay (overall ded waived)[8, 9] $80 Copay (overall ded waived)[8, 9] 80% (up to $250 per prescription[5]) (overall ded waived)[8, 9]
Oral Contraceptives	100% (if in formulary)	100% (overall ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay (overall ded waived)[8, 9]	Applicable Rx Copay (overall ded waived)[8, 9]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	$1,500 Copay[16]	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100%[1]	100% (ded waived)[1]	100% (ded waived)[1]
Chronic Disease Management	$55 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable[15]	80%	80% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$35 Copay	$30 Copay	$25 Copay (ded waived)
Physical, Occupational, Speech Therapy	$35 Copay	$30 Copay	$25 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$35 Copay	$30 Copay	$25 Copay (ded waived)

Services	HMO D	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Gold**	**Gold**	**Gold**
Home Health Care (Max 100 visits per year)	$35 Copay	80%	$30 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$175 Copay	80%	$300 Copay per day – 5 days max per admit
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	80%	80% (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 $1,000 Copay $35 Copay	 80% [12] $30 Copay	 $600 Copay per day – 5 days max per admit [12] $25 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	$1,000 Copay	80% [12]	$600 Copay per day – 5 days max per admit [12]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [10] 100% (in lieu of eyeglasses) (ded waived) [10, 11] 100% (in lieu of contact lenses) (ded waived) [10, 11] 1 pair per year	 VSP Choice Network 100% (ded waived) [10] 100% (in lieu of eyeglasses) (ded waived) [10, 11] 100% (in lieu of contact lenses) (ded waived) [10, 11] 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 [13] 100% 100% $25 Copay [2] $350 Copay [3] $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)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)

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

1. See plan specific EOC for information on preventive services.
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. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
5. Maximum member responsibility.
6. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
7. 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.
8. Cost sharing applies 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 retail 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 $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
9. 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.
10. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
11. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.

(Footnotes continued on page 79)

Gold HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Focus
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,250 / $2,500 [6] (applies to Max OOP)	$1,250 / $2,500 [6] (applies to Max OOP)	$1,250 / $2,500 [6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [2]	$6,500 / $13,000 [2]	$6,500 / $13,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
Specialist Visit (SPC)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)
Laboratory	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
X-Ray	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
MRI, CT and PET (office setting)	$200 Copay per procedure (ded waived)	$200 Copay per procedure (ded waived)	$200 Copay per procedure (ded waived)
Hospital Services – In-Patient	70%	70%	70%
In-Patient Physician Fees	70% (ded waived)	70% (ded waived)	70% (ded waived)
Emergency Room (copay waived if admitted)	70%	70%	70%
Urgent Care	$75 Copay (ded waived)	$75 Copay (ded waived)	$75 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 70% 70%	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) $250 / $500 Ded – $40 Copay [3] $250 / $500 Ded – $80 Copay [3] $250 / $500 Ded – 75% (up to $250 per prescription [5]) [3]	 $15 Copay (ded waived) $250 / $500 Ded – $40 Copay [3] $250 / $500 Ded – $80 Copay [3] $250 / $500 Ded – 75% (up to $250 per prescription [5]) [3]	 $15 Copay (ded waived) $250 / $500 Ded – $40 Copay [3] $250 / $500 Ded – $80 Copay [3] $250 / $500 Ded – 75% (up to $250 per prescription [5]) [3]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [3]	Applicable Ded / Rx Copay [3]	Applicable Ded / 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) [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	$150 Copay (ded waived) [4]	$150 Copay (ded waived) [4]	$150 Copay (ded waived) [4]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Acupuncture	$10 Copay (ded waived)	$10 Copay (ded waived)	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Focus
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	70%	70%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$50 Copay (ded waived)	$50 Copay (ded waived)	$50 Copay (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 70% $30 Copay (ded waived)	 70% $30 Copay (ded waived)	 70% $30 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 70%	 70%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 70% (ded waived) 70% (ded waived) 1 per calendar 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) 70% (ded waived) 70% (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. 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 for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
3. For Specialty drugs, please see plan specific EOC.
4. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
5. Maximum member responsibility.
6. 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.

Gold HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$250 / $500 [1, 7] (applies to Max OOP)	$1,000 / $2,000 [1, 7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [2]	$7,800 / $15,600 [2, 7]	$6,750 / $13,500 [2, 7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay	$25 Copay (ded waived)	$40 Copay (ded waived)
Specialist Visit (SPC)	$40 Copay	$50 Copay (ded waived)	$40 Copay (ded waived)
Laboratory	$40 Copay	$25 Copay (ded waived)	100% (ded waived)
X-Ray	$40 Copay	$65 Copay (ded waived)	100% (ded waived)
MRI, CT and PET (office setting)	$300 Copay	$275 Copay (ded waived)	$300 Copay (ded waived)
Hospital Services – In-Patient	$600 Copay per day	$600 Copay per day [1] – Days 1-5	$500 Copay per day [1] – Days 1-5
In-Patient Physician Fees	100%	100% (ded waived)	100% (ded waived)
Emergency Room (copay waived if admitted)	$300 Copay	$250 Copay	$300 Copay [1]
Urgent Care	$100 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay $300 Copay	 $300 Copay (ded waived) $300 Copay (ded waived)	 $500 Copay [1] $500 Copay [1]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$55 Copay (ded waived)	$40 Copay (ded waived)
Ambulance Services (per trip)	100%	$250 Copay [1]	100% (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay $50 Copay [12] $75 Copay [12] 80% (up to $250 per 30 day supply [9]) [10]	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) [12] $80 Copay (overall ded waived) [12] 80% (up to $250 per 30 day supply [9]) (overall ded waived) [10]	 $10 Copay (ded waived) $250 / $500 Ded – $50 Copay [1, 12] $250 / $500 Ded – $75 Copay [1, 12] $250 / $500 Ded – 80% (up to $250 per 30 day supply [9]) [1, 10]
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$50 Copay	$50 Copay (overall ded waived)	$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% [3, 5]	100% (ded waived) [3, 5]	100% (ded waived) [3,5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	80% (ded waived) [10]	100% (ded waived)
Chiropractic (20 visits max per year)	$15 Copay [8]	$15 Copay (ded waived) [8]	$15 Copay (ded waived) [8]
Acupuncture	$15 Copay	$15 Copay (ded waived)	$15 Copay (ded waived)
Physical, Occupational, Speech Therapy	$40 Copay	$25 Copay (ded waived)	$40 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$40 Copay	$25 Copay (ded waived)	$40 Copay (ded waived)
Home Health Care (Max 100 visits per year)	100%	$30 Copay (ded waived)	100% (ded waived)

Services	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$600 Copay per day	$300 Copay per day[1] – Days 1-5	$500 Copay per day[1] – Days 1-5
Hospice (out-patient)	100%	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80%[4, 10]	80% (ded waived)[4, 10]	80% (ded waived)[4, 10]
Mental Health In-Patient Out-Patient (office visit)	 $600 Copay per day $40 Copay	 $600 Copay per day[1] – Days 1-5 $25 Copay (ded waived)	 $500 Copay per day[1] – Days 1-5 $40 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 $600 Copay per day	 $600 Copay per day[1] – Days 1-5	 $500 Copay per day[1] – Days 1-5
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% 100% 100% 1 per calendar year[6]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year[6]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year[6]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

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

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

Gold HMO

Groups Beginning 7/1/20

Services	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Gold**
Calendar Year Deductible*	$2,000 / $2,800 / $4,000 [1, 9] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [2]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	100% [1]
Specialist Visit (SPC)	100% [1]
Laboratory	100% [1]
X-Ray	100% [1]
MRI, CT and PET (office setting)	100% [1]
Hospital Services – In-Patient	100% [1]
In-Patient Physician Fees	100% [1]
Emergency Room (copay waived if admitted)	100% [1]
Urgent Care	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% [1] 100% [1]
Hospital Pre-Authorization	Required
2nd Surgical Opinion	100% [1]
Ambulance Services (per trip)	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% [1] (combined Med/Rx ded) $30 Copay (combined Med/Rx ded) [1, 10] $50 Copay (combined Med/Rx ded) [1, 10] 80% (up to $250 per 30 day supply [7]) (combined Med/Rx ded) [1, 8]
Oral Contraceptives	100% (ded waived)
Diabetes – Self-Injectable	$30 Copay (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3,5]
Chronic Disease Management	Covered as any Illness
Chemotherapy	100% [1]
Chiropractic (20 visits max per year)	100% [1]
Acupuncture	100% [1]
Physical, Occupational, Speech Therapy	100% [1]
Rehabilitative & Habilitative Services and Devices	100% [1]
Home Health Care (Max 100 visits per year)	100% [1]

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

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. Limited to one pair of glasses with standard lenses or one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.
7. Maximum member responsibility.
8. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
9. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
10. Regardless of medical necessity or generic availability, the member will be responsible for the applicable copayment when a Tier 2 or Tier 3 medication is dispensed. If a Tier1 medication is available and the member elects to receive a Tier 2 or Tier 3 medication without medical indication from the prescribing physician, the member will be responsible for the difference in cost between the Tier 1 and the purchased medication in addition to the Tier 1 copayment. The amount paid for the difference in cost does not contribute to the out-of-pocket maximum.

Gold PPO

Groups Beginning 7/1/20

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $3,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,250 / $12,500 [1]	$12,500 / $25,000 [1]	$6,000 / $12,000 [1]	$12,000 / $24,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
Specialist Visit (SPC)	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Laboratory	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
X-Ray	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
MRI, CT and PET (office setting)	80% [14]	50% (up to $800 per test) [5]	75% [14]	50% (up to $800 per test) [5]
Hospital Services – In-Patient	Tier 1: 80% Tier 2: $500 Copay per admit – 80%	50% (up to $650 per day) [5]	75%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	75%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%		$250 Copay – 75%	
Urgent Care	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 Tier 1: 80% Tier 2: $250 Copay per admit – 80% Tier 1: 80% Tier 2: $250 Copay per admit – 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 75% 75%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [13]		75% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) [2] $200 / $400 Ded – $40 Copay [2] $200 / $400 Ded – $80 Copay [2] $200 / $400 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 $15 Copay (ded waived) [2] $250 / $500 Ded – $40 Copay [2] $250 / $500 Ded – $80 Copay [2] $250 / $500 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered 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	80%	50% [14]	75%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Acupuncture	$30 Copay (ded waived)	Not Covered	$25 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	50% [14]	$25 Copay (ded waived)	50% [14]
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived) [11]	50% [11]	$25 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	75% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 80% [12] Tier 2: $500 Copay per admit – 80% [12]	50% (up to $150 per day) [5, 12]	75% [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%	
Mental Health In-Patient Out-Patient (office visit)	 Tier 1: 80% Tier 2: $500 Copay per admit – 80% $30 Copay (ded waived)	 50% (up to $650 per day) [5] 50%	 75% $25 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 Tier 1: 80% Tier 2: $500 Copay per admit – 80%	 50% (up to $650 per day) [5]	 75%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $30 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $25 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

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Gold PPO

Groups Beginning 7/1/20

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,200 / $2,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,400 / $4,800 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,100 / $10,200 [1]	$10,200 / $20,400 [1]	$5,500 / $11,000 [1]	$11,000 / $22,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
Specialist Visit (SPC)	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Laboratory	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
X-Ray	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
MRI, CT and PET (office setting)	80% [14]	50% (up to $800 per test) [5]	75% [14]	50% (up to $800 per test) [5]
Hospital Services – In-Patient	80%	50% (up to $650 per day) [5]	75%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	75%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%		$250 Copay – 75%	
Urgent Care	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit – 80% $250 Copay per admit – 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 75% 75%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$60 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [13]		75% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) [2] $200 / $400 Ded – $40 Copay [2] $200 / $400 Ded – $80 Copay [2] $200 / $400 Ded – 70% (up to $250 per prescription [8]) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 $15 Copay (ded waived) [2] $300 / $600 Ded – $40 Copay [2] $300 / $600 Ded – $80 Copay [2] $300 / $600 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered 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	80%	50% [14]	75%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$30 Copay (ded waived)	Not Covered	$25 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	50% [14]	$25 Copay (ded waived)	50% [14]

Services	PPO C		PPO D	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived) [11]	50% [11]	$25 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	75% (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)	80% [12]	50% (up to $150 per day) [5, 12]	75% [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%	
Mental Health In-Patient Out-Patient (office visit)	 80% $30 Copay (ded waived)	 50% (up to $650 per day) [5] 50%	 75% $25 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 50% (up to $650 per day) [5]	 75%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $30 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $25 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic &Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

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Gold PPO

Groups Beginning 7/1/20

Services	PPO E	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Gold**	
	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,100 / $10,200 [1]	$10,200 / $20,400 [1]
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%
Specialist Visit (SPC)	$60 Copay (ded waived)	50%
Laboratory	$30 Copay (ded waived)	50%
X-Ray	$60 Copay (ded waived)	50%
MRI, CT and PET (office setting)	80% [14]	50% (up to $800 per test) [5]
Hospital Services –In-Patient	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%	
Urgent Care	$60 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit – 80% $250 Copay per admit – 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required	
2nd Surgical Opinion	$60 Copay (ded waived)	50%
Ambulance Services (per trip)	80% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) [2] $200 / $400 Ded – $40 Copay [2] $200 / $400 Ded – $80 Copay [2] $200 / $400 Ded – 70% (up to $250 per prescription [8]) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness	
Chemotherapy	80%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$30 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$30 Copay (ded waived)	50% [14]

Services	PPO E	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	
Metal Tier	**Gold**	
	In-Network	Out-of-Network [9]
Rehabilitative & Habilitative Services and Devices	$30 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	80% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	
Mental Health In-Patient Out-Patient (office visit)	 80% $30 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $30 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

* 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 1 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.

(Footnotes continued on page 79)

Gold EPO

Groups Beginning 7/1/20

Services	EPO A	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$250 / $500 (combined Med/ Pediatric dental ded)(applies to Max OOP)	$2,000 / $4,000 (combined Med/ Rx/Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000	$7,800 / $15,600	$7,500 / $15,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$25 Copay (ded waived)	$25 Copay (ded waived)
Specialist Visit (SPC)	$50 Copay	$50 Copay (ded waived)	$50 Copay (ded waived)
Laboratory	$50 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
X-Ray	$50 Copay[7]	$65 Copay (ded waived)[7]	$50 Copay (ded waived)[7]
MRI, CT and PET (office setting)	$200 Copay[7]	$275 Copay (ded waived)[7]	80%[7]
Hospital Services – In-Patient	70%	$600 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	70%	100% (ded waived)	80%
Emergency Room (copay waived if admitted)	$350 Copay	$250 Copay	$500 Copay (ded waived)
Urgent Care	$50 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 $300 Copay (ded waived) $300 Copay (ded waived)	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay[5]	$50 Copay (ded waived)[5]	$50 Copay (ded waived)[5]
Ambulance Services (per trip)	$350 Copay	$250 Copay	$500 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay $50 Copay $75 Copay 70% (up to $250 per prescription[3])	 $15 Copay (overall ded waived) $50 Copay (overall ded waived) $80 Copay (overall ded waived) 80% (up to $250 per prescription[3]) (overall ded waived)	 $10 Copay (ded waived) $50 Copay (ded waived) $75 Copay (ded waived) 80% (up to $250 per prescription[3]) (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay (overall ded waived)	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%[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	70%	80% (ded waived)	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$30 Copay	$25 Copay (ded waived)	$25 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay	$25 Copay (ded waived)	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay[6]	$25 Copay (ded waived)[6]	$50 Copay (ded waived)[6]
Home Health Care (Max 100 visits per year)	$50 Copay (Max 100 visits per benefit period)	$30 Copay (ded waived)(Max 100 visits per benefit period)	$50 Copay (ded waived)(Max 100 visits per benefit period)

Services	EPO A	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	$300 Copay per day – 5 days max per admit	80%
Hospice (out-patient)	70%	100% (ded waived)	80%
Durable Medical Equipment (Covered when medically necessary)	70% [8]	80% (ded waived) [8]	80% [8]
Mental Health In-Patient Out-Patient (office visit)	 70% $30 Copay	 $600 Copay per day – 5 days max per admit $25 Copay (ded waived)	 80% $25 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	70%	$600 Copay per day – 5 days max per admit	80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Covered for Evaluation Only [4] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [4] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [4] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision $50 Copay [2, 9] 70% (only in lieu of eyeglasses) 70% 1 pair per calendar year	 Oscar Davis Vision 100% (ded waived) [2, 9] 100% (ded waived) (only in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year	 Oscar Davis Vision $50 Copay (ded waived) [2, 9] 80% (only in lieu of eyeglasses) 80% 1 pair 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)	 Oscar Liberty None Combined with Medical Copay varies by service 100% [2] Copay varies by service Copay varies by service (prior auth. required) $1,000 Copay (prior auth. required)	 Oscar Liberty Combined Med/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service (prior auth. required) $1,000 Copay (prior auth. required)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service (prior auth. required) 80% (prior auth. required)

* 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. Maximum member responsibility.
4. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
5. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
6. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
7. Prior-Authorization may be required.
8. Prior-Authorization required if annual cost is greater than $500.
9. Limit one exam per 12 months.

Gold EPO

Groups Beginning 7/1/20

Services	EPO D
Participating Health Plans	Oscar
Network Name	Oscar EPO
Metal Tier	**Gold**
Calendar Year Deductible*	$1,000 / $2,000 (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	$25 Copay (ded waived)
Specialist Visit (SPC)	$50 Copay (ded waived)
Laboratory	$50 Copay (ded waived)
X-Ray	$50 Copay (ded waived) [6]
MRI, CT and PET (office setting)	80% [6]
Hospital Services – In-Patient	80%
In-Patient Physician Fees	80%
Emergency Room (copay waived if admitted)	$500 Copay (ded waived)
Urgent Care	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%
Hospital Pre-Authorization	Required
2nd Surgical Opinion	$50 Copay (ded waived) [4]
Ambulance Services (per trip)	$500 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) $50 Copay (ded waived) $75 Copay (ded waived) 80% (up to $250 per prescription [9]) (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness
Chemotherapy	80%
Chiropractic (20 visits max per year)	Not Covered
Acupuncture	$25 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [5]
Home Health Care (Max 100 visits per year)	$50 Copay (ded waived)(Max 100 visits per benefit period)

Services	EPO D
Participating Health Plans	Oscar
Network Name	Oscar EPO
Metal Tier	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%
Hospice (out-patient)	80%
Durable Medical Equipment (Covered when medically necessary)	80%[7]
Mental Health In-Patient Out-Patient (office visit)	 80% $25 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Covered for Evaluation Only[3] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision $50 Copay (ded waived)[2, 8] 80% (only in lieu of eyeglasses) 80% 1 pair 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)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived)[2] Copay varies by service Copay varies by service (prior auth. required) 80% (prior auth. required)

* 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. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
4. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
5. Amount listed is for office visits only, please see plan specific EOC for other settings/ services and devices cost share.
6. Prior-Authorization may be required.
7. Prior-Authorization required if annual cost is greater than $500.
8. Limit one exam per 12 months.
9. Maximum member responsibility.

Silver HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,200 / $4,400 [2] (combined Med/ Pediatric dental ded) (applies to Max OOP)	$2,200 / $4,400 [2] (combined Med/ Pediatric dental ded) (applies to Max OOP)	None
Out-of-Pocket Max Ind/Fam	$8,150 / $16,300 [3]	$8,150 / $16,300 [3]	$7,800 / $15,600
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay
Specialist Visit (SPC)	$110 Copay (ded waived)	$110 Copay (ded waived)	$70 Copay
Laboratory	$55 Copay (ded waived) [12]	$55 Copay (ded waived) [12]	$40 Copay
X-Ray	$90 Copay (ded waived) [12]	$90 Copay (ded waived) [12]	$50 Copay
MRI, CT and PET (office setting)	$150 Copay per test (ded waived) [14]	$150 Copay per test (ded waived) [14]	$300 Copay per procedure
Hospital Services – In-Patient	55%	55%	50%
In-Patient Physician Fees	100% (ded waived)	100% (ded waived)	50%
Emergency Room (copay waived if admitted)	$350 Copay – 55%	$350 Copay – 55%	50%
Urgent Care	$60 Copay (ded waived)	$60 Copay (ded waived)	$70 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 55% 55%	 55% 55%	 50% 60% [17]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$110 Copay (ded waived)	$110 Copay (ded waived)	$70 Copay
Ambulance Services (per trip)	55% [8]	55% [8]	50%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [9] $300 / $600 Ded – $80 Copay [9] $300 / $600 Ded – $110 Copay [9] $300 / $600 Ded – 70% (up to $250 per prescription [7])(prior auth. required) [5, 9]	 $20 Copay (ded waived) [9] $300 / $600 Ded - $80 Copay [9] $300 / $600 Ded - $110 Copay [9] $300 / $600 Ded – 70% (up to $250 per prescription [7])(prior auth. required) [5, 9]	 $20 Copay (ded waived) [15, 16] $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] $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]	Applicable Ded / Rx Copay [9]	$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% (ded waived) [1]	100% [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	$70 Copay
Chemotherapy	55% (ded waived) [10]	55% (ded waived) [10]	100%
Chiropractic (20 visits max per year)	$35 Copay (ded waived) (20 visits max per benefit period) [11]	$35 Copay (ded waived) (20 visits max per benefit period) [11]	Not Covered
Acupuncture	$60 Copay (ded waived)	$60 Copay (ded waived)	$10 Copay
Physical, Occupational, Speech Therapy	$60 Copay (ded waived) [12]	$60 Copay (ded waived) [12]	$50 Copay
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived) [12]	$60 Copay (ded waived) [12]	$50 Copay

Services	HMO A	HMO B	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	$110 Copay (ded waived) (Max 100 visits per benefit period) [4]	$110 Copay (ded waived) (Max 100 visits per benefit period) [4]	$50 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	55% [13]	55% [13]	$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 Out-Patient (office visit)	 55% $60 Copay (ded waived)	 55% $60 Copay (ded waived)	 50% [20] $50 Copay [20]
Drug/Substance Abuse In-Patient (Detox Only)	 55%	 55%	 50%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $60 Copay (ded waived) [6] Not Covered Not Covered Not Covered Not Covered	 $60 Copay (ded waived) [6] 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	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year	 EyeMed [19] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% 50% 50% 50%	 Dental Benefit Providers [18, 19] Dental Benefit Providers None Combined with Medical 100% 100% Copay varies by service Copay varies by service Copay varies by service

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

1. 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. 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. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
10. In an office setting.
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.
15. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
16. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
17. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
18. 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.
19. Pediatric dental and vision are included on all plans.
20. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

Silver HMO

Groups Beginning 7/1/20

Services	HMO C	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$1,750 / $3,500 (applies to Max OOP)	$1,800 / $3,600 [6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600	$7,800 / $15,600 [7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$55 Copay (ded waived)
Specialist Visit (SPC)	$70 Copay (ded waived)	$75 Copay (ded waived)
Laboratory	$40 Copay	$25 Copay
X-Ray	$50 Copay	$55 Copay
MRI, CT and PET (office setting)	$300 Copay per procedure	$350 Copay per procedure
Hospital Services – In-Patient	60%	55%
In-Patient Physician Fees	60%	55%
Emergency Room (copay waived if admitted)	60%	55%
Urgent Care	$70 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 70% [14]	 55% 55%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$70 Copay (ded waived)	$75 Copay (ded waived)
Ambulance Services (per trip)	$300 Copay	55%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) [16, 17] $250 / $500 Ded – 60% (up to $250 per prescription [12]) [16, 17] $250 / $500 Ded – 60% (up to $250 per prescription [12]) [16, 17] $250 / $500 Ded – 60% (up to $250 per prescription [16, 17])(prior auth. required) [16, 17]	 $20 Copay (ded waived) $350 / $700 Ded - $75 Copay $350 / $700 Ded - $75 Copay (with physician approval) $350 / $700 Ded – 80% (up to $250 per prescription [12])(with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$250 / $500 Ded –Applicable Rx Copay [16, 17]	$350 / $700 Ded - $75 Copay
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	$70 Copay (ded waived)	Covered as any Illness
Chemotherapy	100% (ded waived)	100% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	$15 Copay (ded waived) [13]
Acupuncture	$10 Copay (ded waived) [9]	$55 Copay (ded waived) [13]
Physical, Occupational, Speech Therapy	$50 Copay (ded waived) [4]	$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [4]	$65 Copay (ded waived)

Services	HMO C	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	$50 Copay (ded waived)	100% (ded waived) [1]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (ded waived) (no limit)	55%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%	55% (ded waived) [8]
Mental Health In-Patient Out-Patient (office visit)	 60% [18] $50 Copay (ded waived) [18]	 55% $55 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 55%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [10] EyeMed 100% (ded waived) 100% (ded waived) 1 pair per calendar year (ded waived) None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [15] 1 pair per calendar year (ded waived) [15] 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 [10, 11] Dental Benefit Providers None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [2] $365 Copay [3] $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. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
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. Must be medically necessary.
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.
16. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
17. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
18. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.

Silver HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C	HMO D† HSA Qualified
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,650 / $3,300[3] (applies to Max OOP)	$2,250 / $4,500[5] (applies to Max OOP)	$2,500 / $2,800 / $5,000[7] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600[8]	$7,800 / $15,600[8]	$6,850 / $13,700[8]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$55 Copay (ded waived)	$50 Copay (ded waived)	80%
Specialist Visit (SPC)	$80 Copay (ded waived)	$85 Copay (ded waived)	80%
Laboratory	$25 Copay (ded waived)	$40 Copay (ded waived)	80%
X-Ray	$75 Copay	$85 Copay (ded waived)	80%
MRI, CT and PET (office setting)	$350 Copay per procedure	$300 Copay per procedure (ded waived)	80% per procedure
Hospital Services – In-Patient	60%	80%	80%
In-Patient Physician Fees	60%	80%	80%
Emergency Room (copay waived if admitted)	60%	$400 Copay	80%
Urgent Care	$55 Copay (ded waived)	$50 Copay (ded waived)	80%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 80% (ded waived) 80% (ded waived)	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$80 Copay (ded waived)	$85 Copay (ded waived)	80%
Ambulance Services (per trip)	60%	$250 Copay	80%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $350 / $700 Ded – $75 Copay $350 / $700 Ded – $75 Copay (with physician approval) $350 / $700 Ded – 80% (up to $250 per prescription[9]) (with physician approval)	 $300 / $600 Ded – $17 Copay $300 / $600 Ded – $65 Copay $300 / $600 Ded – $65 Copay (with physician approval) $300 / $600 Ded – 80% (up to $250 per prescription[9]) (with physician approval)	 80% (Up to $250 per prescription[9]) (combined Med/Rx ded) 80% (Up to $250 per prescription[9]) (combined Med/Rx ded) 80% (Up to $250 per prescription[9]) (combined Med/Rx ded) (with physician approval) 80% (up to $250 per prescription[9]) (combined Med/Rx ded) (with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$350 / $700 Ded – $75 Copay	$300 / $600 Ded – $65 Copay	80% (Up to $250 per prescription[9]) (combined Med/Rx ded)
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	100% (ded waived)	80% (ded waived)	80%
Chiropractic (20 visits max per year)	$15 Copay (ded waived)[2]	Not Covered	Not Covered
Acupuncture	$55 Copay (ded waived)[2]	$50 Copay (ded waived)	80%
Physical, Occupational, Speech Therapy	$65 Copay (ded waived)	$50 Copay (ded waived)	80%
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived)	$50 Copay (ded waived)	80%

Services	HMO B	HMO C	HMO D† HSA Qualified
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	100% (ded waived) [10]	$45 Copay (ded waived) [10]	80% [10]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	80%	80%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	60% (ded waived) [6]	80% (ded waived) [6]	80% [6]
Mental Health			
In-Patient	60%	80%	80%
Out-Patient (office visit)	$55 Copay (ded waived)	$50 Copay (ded waived)	80%
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	80%	80%
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Exam	100% (ded waived)	100% (ded waived)	100% (ded waived)
Contact Lenses	1 pair per calendar year [11]	1 pair per calendar year [11]	1 pair per calendar year [11]
Frames	1 pair per calendar year (ded waived) [11]	1 pair per calendar year (ded waived) [11]	1 pair per calendar year (ded waived) [11]
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700	$350 / $700
Office Visit	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	$95 Copay [4]	$95 Copay [4]	$95 Copay [4]
Major Services (no waiting period)	$365 Copay [5]	$365 Copay [5]	$365 Copay [5]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$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. 20 visits max per year combined for Chiropractic and Acupuncture.
3. 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.
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. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. $2,500 Self only enrollment, $2,800 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.

Silver HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C
Participating Health Plans	Sharp	Sharp	Sharp
Network Name	Premier	Performance	Premier
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,300 / $4,600[7] (applies to Max OOP)	$2,300 / $4,600[7] (applies to Max OOP)	$2,500 / $5,000[7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000[2, 7]	$8,000 / $16,000[2, 7]	$8,000 / $16,000[2, 7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Specialist Visit (SPC)	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Laboratory	$15 Copay	$15 Copay	$15 Copay
X-Ray	$55 Copay	$50 Copay	$50 Copay
MRI, CT and PET (office setting)	$175 Copay per procedure	$175 Copay per procedure	$175 Copay per procedure
Hospital Services – In-Patient	$850 Copay per day	60%	50%
In-Patient Physician Fees	100%	60%	50%
Emergency Room (copay waived if admitted)	$700 Copay	60%	50%
Urgent Care	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 50% 50%	 60% 60%	 50% 50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Ambulance Services (per trip)	$400 Copay (ded waived)	60% (ded waived)	50% (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $200 / $400 Ded – $105 Copay $200 / $400 Ded – $135 Copay $200 / $400 Ded – Applicable Rx Copay	 $20 Copay (ded waived) $200 / $400 Ded – $100 Copay $200 / $400 Ded – $160 Copay $200 / $400 Ded – Applicable Rx Copay	 $20 Copay (overall ded waived) $100 Copay (overall ded waived) $150 Copay (overall ded waived) Applicable Rx Copay (overall ded waived)
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100% (overall ded waived)
Diabetes – Self-Injectable	$200 / $400 Ded – Applicable Rx Copay	$200 / $400 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	$800 Copay per day[8]	60%[8]	50%[8]
Preventive/Wellness Services	100% (ded waived)[1]	100% (ded waived)[1]	100% (ded waived)[1]
Chronic Disease Management	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Chemotherapy	Variable[3]	Variable[3]	Variable[3]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Physical, Occupational, Speech Therapy	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$40 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)

Services	HMO A	HMO B	HMO C
Participating Health Plans	Sharp	Sharp	Sharp
Network Name	Premier	Performance	Premier
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day	60%	50%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	50%	50%
Mental Health In-Patient Out-Patient (office visit)	 $125 Copay per day $40 Copay (ded waived)	 60% $40 Copay (ded waived)	 50% $40 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 $125 Copay per day	 60%	 50%
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 VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [4] 100% 100% $25 Copay [5] $350 Copay [6] $350 Copay	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [4] 100% 100% $25 Copay [5] $350 Copay [6] $350 Copay	 Access Dental Access Dental Plan Children's Dental HMO None $350 / $700 [4] 100% 100% $25 Copay [5] $350 Copay [6] $350 Copay

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

1. See plan specific EOC for information on preventive services.
2. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
3. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
4. 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.
5. 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.
6. 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.
7. 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.

8 Amount listed for In-Patient Services only

Silver HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C† HSA Qualified	HMO A
Participating Health Plans	Sutter Health Plus	Sutter Health Plus	UnitedHealthcare
Network Name	Sutter Health Plus	Sutter Health Plus	SignatureValue
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,250 / $4,500 [7] (applies to Max OOP)	$2,500 / $2,800 / $5,000 [7,10] (combined Med/Rx ded) (applies to Max OOP)	$2,250 / $4,500 [4] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [9]	$6,000 / $12,000 [9]	$8,150 / $16,300 [5]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived) [8]	$35 Copay [8]	$55 Copay (ded waived)
Specialist Visit (SPC)	$85 Copay (ded waived)	$50 Copay	$80 Copay (ded waived)
Laboratory	$40 Copay (ded waived)	$35 Copay	$45 Copay (ded waived)
X-Ray	$85 Copay per procedure (ded waived)	$15 Copay per procedure	$45 Copay (ded waived)
MRI, CT and PET (office setting)	$300 Copay per procedure (ded waived)	$50 Copay per procedure	$200 Copay per procedure (ded waived)
Hospital Services – In-Patient	80%	80%	60%
In-Patient Physician Fees	80% (ded waived)	80%	60% (ded waived)
Emergency Room (copay waived if admitted)	$400 Copay	80%	60%
Urgent Care	$50 Copay (ded waived)	$35 Copay	$100 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% (ded waived) 80% (ded waived)	 80% 80%	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$85 Copay (ded waived)	$50 Copay	$80 Copay (ded waived)
Ambulance Services (per trip)	$250 Copay	80%	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $300 / $600 Ded – $17 Copay [11] $300 / $600 Ded – $65 Copay [11, 12] $300 / $600 Ded – $90 Copay [11, 12] $300 / $600 Ded – 80% (up to $250 per prescription [3]) [11, 12]	 $10 Copay (combined Med/Rx ded) [11] $20 Copay (combined Med/Rx ded) [11, 12] $40 Copay (combined Med/Rx ded) [11, 12] 80% (up to $250 per prescription [3]) (combined Med/Rx ded) [11, 12]	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [2] $300 / $600 Ded – $100 Copay [2] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$300 / $600 Ded – Applicable Rx Copay [11, 12]	Applicable Rx Copay (combined Med/Rx ded) [11, 12]	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% (ded waived)	80%	$150 Copay (ded waived) [6]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	$15 Copay (ded waived)
Acupuncture	$50 Copay (ded waived)	$35 Copay	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	$35 Copay	$55 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived)	$35 Copay	$55 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	80%	$55 Copay (ded waived)

Services	HMO B	HMO C† HSA Qualified	HMO A
Participating Health Plans	Sutter Health Plus	Sutter Health Plus	UnitedHealthcare
Network Name	Sutter Health Plus	Sutter Health Plus	SignatureValue
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%	60%
Hospice (out-patient)	100% (ded waived)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived)	80%	$50 Copay (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 80% [13] $50 Copay (ded waived)	 80% [13] $35 Copay	 60% $55 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 80% [13]	 80% [13]	 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 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	 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) 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 neces-sary)	 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)	 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)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. For Specialty drugs, please see plan specific EOC.
3. Maximum member responsibility.
4. 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.
5. 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 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.
6. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
7. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
8. 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.
9. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
10. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
11. Cost sharing applies 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 retail 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 $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

(Footnotes continued on page 79)

Silver HMO

Groups Beginning 7/1/20

Services	HMO B	HMO C	HMO D
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Advantage	Alliance	Focus
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,250 / $4,500 [5] (applies to Max OOP)	$2,250 / $4,500 [5] (applies to Max OOP)	$2,250 / $4,500 [5] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,150 / $16,300 [6]	$8,150 / $16,300 [6]	$8,150 / $16,300 [6]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Specialist Visit (SPC)	$80 Copay (ded waived)	70%	$80 Copay (ded waived)
Laboratory	$45 Copay (ded waived)	70%	$45 Copay (ded waived)
X-Ray	$45 Copay (ded waived)	70%	$45 Copay (ded waived)
MRI, CT and PET (office setting)	$200 Copay per procedure (ded waived)	70%	$200 Copay per procedure (ded waived)
Hospital Services – In-Patient	60%	70%	60%
In-Patient Physician Fees	60% (ded waived)	70%	60% (ded waived)
Emergency Room (copay waived if admitted)	60%	70%	60%
Urgent Care	$100 Copay (ded waived)	70%	$100 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 70% 70%	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$80 Copay (ded waived)	70%	$80 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	70%	$100 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [4] $300 / $600 Ded – $100 Copay [4] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [4]	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [4] $300 / $600 Ded – $100 Copay [4] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [4]	 $20 Copay (ded waived) $300 / $600 Ded – $50 Copay [4] $300 / $600 Ded – $100 Copay [4] $300 / $600 Ded – 75% (up to $250 per prescription [3]) [4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [4]	Applicable Ded / Rx Copay [4]	Applicable Ded / Rx Copay [4]
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	$150 Copay (ded waived) [2]	70%	$150 Copay (ded waived) [2]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	70%	$15 Copay (ded waived)
Acupuncture	$10 Copay (ded waived)	70%	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$55 Copay (ded waived)	70%	$55 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	70%	60%

Services	HMO B	HMO C	HMO D
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Advantage	Alliance	Focus
Metal Tier	**Silver**	**Silver**	**Silver**
Hospice (out-patient)	100% (ded waived)	70%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	$50 Copay (ded waived)	70%	$50 Copay (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 60% $55 Copay (ded waived)	 70% 70%	 60% $55 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 70%	 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 Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 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
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	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

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

1. See plan specific EOC for information on preventive services.
2. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
3. Maximum member responsibility.
4. For Specialty drugs, please see plan specific EOC.
5. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
6. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services 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.

Silver HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,300 / $4,600 [1, 10] (applies to Max OOP)	$2,250 / $4,500 [1, 10] (applies to Max OOP)	$2,500 / $2,800 / $5,000 [1, 9, 10] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [2, 10]	$7,800 / $15,600 [2, 10]	$6,850 / $13,700 [2, 10]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$50 Copay (ded waived)	80% [1, 4]
Specialist Visit (SPC)	$50 Copay (ded waived)	$85 Copay (ded waived)	80% [1, 4]
Laboratory	$50 Copay (ded waived)	$40 Copay (ded waived)	80% [1, 4]
X-Ray	$75 Copay (ded waived)	$85 Copay (ded waived)	80% [1, 4]
MRI, CT and PET (office setting)	$350 Copay (ded waived)	$300 Copay (ded waived)	80% [1, 4]
Hospital Services – In-Patient	70% [1, 4]	80% [1, 4]	80% [1, 4]
In-Patient Physician Fees	100% (ded waived)	80% (ded waived) [4]	80% [1, 4]
Emergency Room (copay waived if admitted)	70% [1, 4]	$400 Copay [1]	80% [1, 4]
Urgent Care	$100 Copay [1]	$50 Copay (ded waived)	80% [1, 4]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $350 Copay [1] $350 Copay [1]	 80% (ded waived) [4] 80% (ded waived) [4]	 80% [1, 4] 80% [1, 4]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay (ded waived)	$85 Copay (ded waived)	80% [1, 4]
Ambulance Services (per trip)	100% (ded waived)	$250 Copay [1]	80% [1, 4]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) $250 / $500 Ded – $55 Copay [1, 11] $250 / $500 Ded – $85 Copay [1, 11] $250 / $500 Ded – 70% (up to $250 per 30 day supply [8]) [1, 4]	 $300 / $600 Ded – $17 Copay [1] $300 / $600 Ded – $65 Copay [1, 11] $300 / $600 Ded – $90 Copay [1, 11] $300 / $600 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] 80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4, 11] 80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4, 11] 80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$250 / $500 Ded – $55 Copay [1]	$300 / $600 Ded – $65 Copay [1]	80% (up to $250 per 30 day supply [8]) (combined Med/Rx ded) [1, 4]
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) [3, 6]	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100% (ded waived)	80% [1, 4]	80% [1, 4]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$15 Copay (ded waived)	$15 Copay (ded waived)	100% [1]
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	$50 Copay (ded waived)	80% [1, 4]
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived)	$50 Copay (ded waived)	80% [1, 4]

Silver HMO

Groups Beginning 7/1/20

Services	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	100% (ded waived)	$45 Copay (ded waived)	80% [1, 4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70% [1, 4]	80% [1, 4]	80% [1, 4]
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	80% (ded waived) [4, 5]	80% (ded waived) [4, 5]	80% [1, 4, 5]
Mental Health In-Patient Out-Patient (office visit)	 70% [1, 4] $50 Copay (ded waived)	 80% [1, 4] $50 Copay (ded waived)	 80% [1, 4] 80% [1, 4]
Drug/Substance Abuse In-Patient (Detox Only)	 70% [1, 4]	 80% [1, 4]	 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	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [7]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [7]	 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)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deducible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. 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 7/1/20

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*	$1,600 / $3,200 (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,200 / $6,400 (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	$8,000 / $16,000 [1]	$16,000 / $32,000 [1]	$8,150 / $16,300 [1]	$16,300 / $32,600 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$45 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Specialist Visit (SPC)	$90 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
Laboratory	$45 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
X-Ray	$90 Copay (ded waived)	50%	$95 Copay (ded waived)	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]	65%	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	$90 Copay (ded waived)	50%	$95 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	$90 Copay (ded waived)	50%	$95 Copay (ded waived)	50%
Ambulance Services (per trip)	60% [13]		65% [13]	
Rx Benefits				
Generic	$20 Copay (ded waived) [2]	Not Covered	$20 Copay (ded waived) [2]	Not Covered
Formulary Brand	$350 / $700 Ded - $50 Copay [2]	Not Covered	$350 / $700 Ded – $50 Copay [2]	Not Covered
Non-Formulary Brand	$350 / $700 Ded - $90 Copay [2]	Not Covered	$350 / $700 Ded – $90 Copay [2]	Not Covered
Specialty	$350 / $700 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	$45 Copay (ded waived)	Not Covered	$50 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$45 Copay (ded waived)	50% [14]	$50 Copay (ded waived)	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	$45 Copay (ded waived) [11]	50% [11]	$50 Copay (ded waived) [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]	65% [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%	
Mental Health In-Patient Out-Patient (office visit)	 Tier 1: 60% Tier 2: $500 Copay per admit – 60% $45 Copay (ded waived)	 50% (up to $650 per day) [5] 50%	 65% $50 Copay (ded waived)	 50% (up to $650 per day) [5] 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]	 65%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $45 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 $50 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) $0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)(1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

(Footnotes continued on page 80)

Silver PPO

Groups Beginning 7/1/20

Services	PPO C	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Silver**	
	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$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	$8,150 / $16,300 [1]	$16,300 / $32,600 [1]
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	$50 Copay (ded waived)	50%
Specialist Visit (SPC)	$95 Copay (ded waived)	50%
Laboratory	$50 Copay (ded waived)	50%
X-Ray	$95 Copay (ded waived)	50%
MRI, CT and PET (office setting)	65%	50% (up to $800 per test) [5]
Hospital Services – In-Patient	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%
Emergency Room (copay waived if admitted)	$300 Copay – 65%	
Urgent Care	$95 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay per admit – 65% $300 Copay per admit – 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required	
2nd Surgical Opinion	$95 Copay (ded waived)	50%
Ambulance Services (per trip)	65% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [2] $350 / $700 Ded – $50 Copay [2] $350 / $700 Ded – $90 Copay [2] $350 / $700 Ded – 70% (up to $250 per prescription [8]) (prior auth.required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness	
Chemotherapy	65%	50% [14]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$50 Copay (ded waived)	Not Covered
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	50% [14]
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived) [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]

Services	PPO C	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	
Metal Tier	**Silver**	
	In-Network	Out-of-Network [9]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	
Mental Health In-Patient Out-Patient (office visit)	 65% $50 Copay (ded waived)	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 65%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $50 Copay (ded waived) [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

* 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 1 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.

(Footnotes continued on page 80)

Silver EPO

Groups Beginning 7/1/20

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 / $2,800 / $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)	70%
Specialist Visit (SPC)	$100 Copay (ded waived)	70%
Laboratory	$50 Copay (ded waived)	70%
X-Ray	$100 Copay (ded waived)	70%
MRI, CT and PET (office setting)	65% [14]	70%
Hospital Services – In-Patient	65%	70%
In-Patient Physician Fees	65%	70%
Emergency Room (copay waived if admitted)	$300 Copay – 65%	70%
Urgent Care	$100 Copay (ded waived)	70%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay per admit – 65% $300 Copay per admit – 65%	 70% 70%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$100 Copay (ded waived)	70%
Ambulance Services (per trip)	65% [8]	70% [8]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [10] $300 / $600 Ded – $50 Copay [10] $300 / $600 Ded – $90 Copay [10] $300 / $600 Ded – 70% (up to $250 per prescription [7]) (prior auth. required) [5, 10]	 70% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [10] 70% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [10] 70% (up to $250 per prescription [7]) (combined Med/Rx/Pediatric dental ded) [10] 70% (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]	Applicable Ded / Rx Copay [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%	70%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	50% (20 visits max per benefit period) [11]
Acupuncture	$50 Copay (ded waived)	70%
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	70%

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	$50 Copay (ded waived) [12]	70% [12]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	70% (Max 100 visits per benefit period) [4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [13]	70% [13]
Hospice (out-patient)	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%
Mental Health In-Patient Out-Patient (office setting)	 65% $50 Copay (ded waived)	 70% 70%
Drug/Substance Abuse In-Patient (Detox Only)	 65%	 70%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $50 Copay (ded waived) [6] Not Covered Not Covered Not Covered Not Covered	 70% [6] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded Combined with Medical 100% 100% 50% 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: $2,800 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 1 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 7/1/20

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 / $2,800 / $5,000 [3] (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$2,250 / $4,500 (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	$6,850 / $13,700	$7,800 / $15,600	$8,150 / $16,300
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	80%	$50 Copay (ded waived)	$50 Copay (ded waived)
Specialist Visit (SPC)	80%	$85 Copay (ded waived)	$75 Copay (ded waived)
Laboratory	80%	$40 Copay (ded waived)	$75 Copay (ded waived)
X-Ray	80% [8]	$85 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%	$400 Copay	$750 Copay (ded waived)
Urgent Care	80%	$50 Copay (ded waived)	$75 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 80% (ded waived) 80% (ded waived)	 50% 50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	80% [6]	$85 Copay (ded waived) [6]	$75 Copay (ded waived) [6]
Ambulance Services (per trip)	80%	$250 Copay	$750 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded) 80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded) 80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded) 80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	 $300 / $600 Ded - $17 Copay $300 / $600 Ded - $65 Copay $300 / $600 Ded - $90 Copay $300 / $600 Ded – 80% (up to $250 per prescription [4])	 $25 Copay (ded waived) $55 Copay (ded waived) $125 Copay (ded waived) 50% (up to $250 per prescription [4]) (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	Not Covered
Acupuncture	80%	$50 Copay (ded waived)	$50 Copay (ded waived)
Physical, Occupational, Speech Therapy	80%	$50 Copay (ded waived)	$75 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	80% [7]	$50 Copay (ded waived) [7]	$75 Copay (ded waived) [7]

Silver EPO

Groups Beginning 7/1/20

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% (Max 100 visits per benefit period)	$45 Copay (ded waived)(Max 100 visits per benefit period)	$75 Copay (ded waived)(Max 100 visits per benefit period)
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 Out-Patient (office visit)	 80% 80%	 80% $50 Copay (ded waived)	 50% $50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 80%	 50%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Covered for Evaluation Only [5] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [5] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [5] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision 100% (ded waived) [2, 10] 100% (ded waived)(only in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year	 Oscar Davis Vision 100% (ded waived) [2, 10] 100% (ded waived)(only in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year	 Oscar Davis Vision $75 Copay (ded waived) [2, 10] 50% (only in lieu of eyeglasses) 50% 1 pair 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)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service (prior auth. required) 50% (ded waived) (prior auth. required)	 Oscar Liberty Combined Med/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service (prior auth. required) $1,000 Copay (ded waived) (prior auth. required)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service (prior auth. required) $1,000 Copay (ded waived) (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.

Bronze HMO

Groups Beginning 7/1/20

Services	HMO A	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 (applies to Max OOP)	$6,300 / $12,600 [17] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600	$7,800 / $15,600 [2]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay [9]	$65 Copay [9]
Specialist Visit (SPC)	$95 Copay [9]	$95 Copay [9]
Laboratory	$40 Copay (ded waived)	$40 Copay (ded waived)
X-Ray	60%	60%
MRI, CT and PET (office setting)	60%	60% per procedure
Hospital Services – In-Patient	60%	60%
In-Patient Physician Fees	60%	60%
Emergency Room (copay waived if admitted)	60%	60%
Urgent Care	$65 Copay [9]	$65 Copay [9]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60% [11]	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$65 Copay [9]	$95 Copay [9]
Ambulance Services (per trip)	60%	60%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – $18 Copay [13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription [6]) [13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription [6]) [13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription [6])(prior auth. required) [13, 14]	 $500 / $1,000 Ded – $18 Copay $500 / $1,000 Ded – 60% (up to $500 per prescription [6]) $500 / $1,000 Ded – 60% (up to $500 per prescription [6])(with physician approval) $500 / $1,000 Ded – 60% (up to $500 per prescription [6])(with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – Applicable Rx Copay	$500 / $1,000 Ded – 60% (up to $500 per prescription [6])
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	$95 Copay [9]	Covered as any illness
Chemotherapy	60%	60%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	$65 Copay [9, 16]	$65 Copay [9]
Physical, Occupational, Speech Therapy	$65 Copay (ded waived) [1]	$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived) [1]	$65 Copay (ded waived)

Services	HMO A	HMO A
Participating Health Plans	Health Net	Kaiser Permanente
Network Name	CommunityCare	Full
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	60% [10]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% (no limit)	60%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%	60%
Mental Health In-Patient Out-Patient (office visit)	 60% [15] $65 Copay (ded waived) [15]	 60% $65 Copay [9]
Drug/Substance Abuse In-Patient (Detox Only)	 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
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [3] EyeMed 100% (ded waived) 100% (ded waived) 1 pair per calendar year (ded waived) None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [12] 1 pair per calendar year (ded waived) [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 Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [7] $365 Copay [8] $350 Copay

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

1. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
2. 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.
3. Pediatric dental and vision are included on all plans.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
6. Maximum member responsibility.
7. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
8. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
9. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).
10. 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. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
12. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
13. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
14. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
15. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
16. Must be medically necessary.
17. 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.

Bronze HMO

Groups Beginning 7/1/20

Services	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,900 / $13,800 [12] (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	$6,900 / $13,800 [13]	$7,900 / $15,800 [4, 11]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	$55 Copay
Specialist Visit (SPC)	100%	$55 Copay
Laboratory	100%	$15 Copay
X-Ray	100%	$55 Copay
MRI, CT and PET (office setting)	100% per procedure	$175 Copay per procedure
Hospital Services – In-Patient	100%	$1,500 Copay per day – 3 days max
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	100%	$500 Copay
Urgent Care	100%	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% 100%	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	100%	$55 Copay
Ambulance Services (per trip)	100%	$500 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) (with physician approval) 100% (combined Med/Rx ded) (with physician approval)	 $19 Copay (ded waived) $60 Copay (combined Med/Rx ded) $100 Copay (combined Med/Rx ded) Applicable Rx Copay (combined Med/Rx ded)
Oral Contraceptives	100% (ded waived)	100% (if in formulary)
Diabetes – Self-Injectable	100% (combined Med/Rx ded)	Applicable Rx Copay (combined Med/Rx ded)
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	$800 Copay per day – 3 days max [9]
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	Covered as any Illness	$55 Copay
Chemotherapy	100%	Variable [8]
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	100%	$55 Copay
Physical, Occupational, Speech Therapy	100%	$55 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	100%	$55 Copay
Home Health Care (Max 100 visits per year)	100% [1]	$55 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%	$25 Copay per day
Hospice (out-patient)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	100% [6]	50%
Mental Health		
In-Patient	100%	$125 Copay per day – 3 days max
Out-Patient (office visit)	100%	$55 Copay
Drug/Substance Abuse		
In-Patient (Detox Only)	100%	$125 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.

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. 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.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. The pediatric dental out-of-pocket maximum is $350 for a family with one child and $700 for a family with 2 or more children.
8. Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
9. Amount listed for In-Patient Services only.
10. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
11. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
12. 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.
13. 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.

Bronze HMO

Groups Beginning 7/1/20

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]	$7,800 / $15,600 [2]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$65 Copay [8, 9]
Specialist Visit (SPC)	60%	$95 Copay [8]
Laboratory	60%	$40 Copay (ded waived)
X-Ray	60%	60%
MRI, CT and PET (office setting)	60%	60%
Hospital Services – In-Patient	60%	60%
In-Patient Physician Fees	60%	60%
Emergency Room (copay waived if admitted)	60%	60%
Urgent Care	60%	$65 Copay [8]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	60%	$95 Copay [8]
Ambulance Services (per trip)	60%	60%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded)	 $500 / $1,000 Ded – $18 Copay [3] $500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 60% (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, 4]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	60% [18]	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]	60%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	60%	$65 Copay [8]
Physical, Occupational, Speech Therapy	60%	$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	60%	$65 Copay (ded waived)
Home Health Care (Max 100 visits per year)	60%	60%

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%	60%
Hospice (out-patient)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	50%	60%
Mental Health		
In-Patient	60%	60% [16]
Out-Patient (office visit)	60%	$65 Copay [8]
Drug/Substance Abuse		
In-Patient (Detox Only)	60%	60% [16]
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. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
2. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
3. Cost sharing applies 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 retail 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 $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 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 under age 19 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.

(Footnotes continued on page 80)

Bronze HMO

Groups Beginning 7/1/20

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plus	Alliance	Alliance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,900 / $13,800 [3] (combined Med/Rx ded) (applies to Max OOP)	$7,200 / $14,400 [2] (applies to Max OOP)	$6,900 / $13,800 [2] (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,900 / $13,800 [5]	$8,150 / $16,300 [4]	$6,900 / $13,800 [4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	100% [7]	60%	100%
Specialist Visit (SPC)	100%	60%	100%
Laboratory	100%	60%	100%
X-Ray	100%	60%	100%
MRI, CT and PET (office setting)	100%	60%	100%
Hospital Services – In-Patient	100%	60%	100%
In-Patient Physician Fees	100%	60%	100%
Emergency Room (copay waived if admitted)	100%	60%	100%
Urgent Care	100%	60%	100%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% 100%	 60% 60%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	100%	60%	100%
Ambulance Services (per trip)	100%	60%	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% (combined Med/Rx ded) [9] 100% (combined Med/Rx ded) [9, 10] 100% (combined Med/Rx ded) [9, 10] 100% (combined Med/Rx ded) [9, 10]	 $20 Copay (ded waived) $350 / $700 Ded – $50 Copay [6] $350 / $700 Ded – $100 Copay [6] $350 / $700 Ded – 60% (up to $500 per prescription [8]) [6]	 100% (combined Med/Rx/ Pediatric dental ded) 100% (combined Med/Rx/ Pediatric dental ded) [6] 100% (combined Med/Rx/ Pediatric dental ded) [6] 100% (combined Med/Rx/Pediatric dental ded) [6]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (combined Med/Rx ded) [9]	Applicable Ded / Rx Copay [6]	100% (combined Med/Rx/Pediatric dental ded) [6]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	60%	100%
Chiropractic (20 visits max per year)	Not Covered	$15 Copay	100%
Acupuncture	100%	60%	100%
Physical, Occupational, Speech Therapy	100%	60%	100%
Rehabilitative & Habilitative Services and Devices	100%	60%	100%

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plus	Alliance	Alliance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	100%	60%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%	60%	100%
Hospice (out-patient)	100%	60%	100%
Durable Medical Equipment (Covered when medically necessary)	100%	60%	100%
Mental Health In-Patient Out-Patient (office visit)	 100% [13] 100%	 60% 60%	 100% 100%
Drug/Substance Abuse In-Patient (Detox Only)	 100% [13]	 60%	 100%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% (ded waived) [11] 100% (in lieu of eyeglasses) (ded waived) [11, 12] 100% (in lieu of contact lenses) (ded waived) [11, 12] 1 pair per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 100% 100% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)	 UnitedHealthcare Dental CA DHMO 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 Combined Med/Rx/Pediatric dental ded Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† 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. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 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 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. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
6. For Specialty drugs, please see plan specific EOC.
7. 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.
8. Maximum member responsibility.

(Footnotes continued on page 80)

Bronze HMO

Groups Beginning 7/1/20

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)	$6,900 / $13,800 [1, 7] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [2, 7]	$6,900 / $13,800 [2, 7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay [9]	100% [1]
Specialist Visit (SPC)	$95 Copay [9]	100% [1]
Laboratory	$40 Copay (ded waived)	100% [1]
X-Ray	60% [1, 4]	100% [1]
MRI, CT and PET (office setting)	60% [1, 4]	100% [1]
Hospital Services – In-Patient	60% [1, 4]	100% [1]
In-Patient Physician Fees	60% [1, 4]	100% [1]
Emergency Room (copay waived if admitted)	60% [1, 4]	100% [1]
Urgent Care	$65 Copay [1]	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$95 Copay [9]	100% [1]
Ambulance Services (per trip)	60% [1, 4]	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – $18 Copay [1] $500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4, 11] $500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4, 11] $500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4]	 100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – 60% (up to $500 per prescription [8]) [1, 4]	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	60% [1, 4]	100% [1]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$15 Copay [1]	100% [1]
Physical, Occupational, Speech Therapy	$65 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived)	100% [1]
Home Health Care (Max 100 visits per year)	60% [1, 4]	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)	60% [1, 4]	100% [1]
Hospice (out-patient)	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	60% [1, 4, 5]	100% [1]
Mental Health In-Patient Out-Patient (office visit)	 60% [1, 4] $65 Copay [9]	 100% [1] 100% [1]
Drug/Substance Abuse In-Patient (Detox Only)	 60% [1, 11]	 100% [1]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [10]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [10]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.
8. Maximum member responsibility.
9. Deductible waived for first three non-preventive care visits.
10. Limited to one pair of glasses with standard lenses or one pair of standard hard or six soft contact lenses instead of glasses.
11. 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

Bronze PPO

Groups Beginning 7/1/20

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$5,400 / $10,800 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$10,800 / $21,600 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$5,400 / $10,800 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$10,800 / $21,600 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,900 / $13,800 [1]	$13,800 / $27,600 [1]	$6,900 / $13,800 [1]	$13,800 / $27,600 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	65%	50%	65%	50%
Specialist Visit (SPC)	65%	50%	65%	50%
Laboratory	65%	50%	65%	50%
X-Ray	65%	50%	65%	50%
MRI, CT and PET (office setting)	65%	50% (up to $800 per test) [5]	65%	50% (up to $800 per test) [5]
Hospital Services –In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%		65%	
Urgent Care	65%	50%	65%	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 65% 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 65% 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	65%	50%	65%	50%
Ambulance Services (per trip)	65% [13]		65% [13]	
Rx Benefits Generic	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered
Formulary Brand	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered
Non-Formulary Brand	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2]	Not Covered
Specialty	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2, 6]	Not Covered	65% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [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	65%	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	65%	Not Covered	65%	Not Covered
Physical, Occupational, Speech Therapy	65%	50% [14]	65%	50% [14]

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Rehabilitative & Habilitative Services and Devices	65% [11]	50% [11]	65% [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (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)	65% [12]	50% (up to $150 per day) [5, 12]	65% [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%	
Mental Health In-Patient Out-Patient (office visit)	 65% 65%	 50% (up to $650 per day) [5] 50%	 65% 65%	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 65%	 50% (up to $650 per day) [5]	 65%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 65% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 65% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

† 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.

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 1 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.

(Footnotes continued on page 81)

Bronze EPO

Groups Beginning 7/1/20

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)	$6,900 / $13,800 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$8,150 / $16,300 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000 [2]	$6,900 / $13,800	$8,150 / $16,300
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay	100%	100%
Specialist Visit (SPC)	$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 Ambulatory Surgery Center	 60% 60%	 100% 100%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$85 Copay	100% [18]	100% [18]
Ambulance Services (per trip)	60% [10]	100%	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [9] $60 Copay (combined Med/Rx/Pediatric dental ded) [9] $100 Copay (combined Med/Rx/Pediatric dental ded) [9] 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) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 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]	Not Covered	Not Covered
Acupuncture	$65 Copay	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% (Max 100 visits per benefit period)	100% (Max 100 visits per benefit period)
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 Out-Patient (office visit)	 60% 60%	 100% 100%	 100% 100%
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 100%	 100%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $65 Copay [7] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [17] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [17] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year	 Oscar Davis Vision 100% (ded waived) [8, 15] 100% (ded waived) (only in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year	 Oscar Davis Vision 100% [8, 15] 100% (only in lieu of eyeglasses) 100% 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded Combined with Medical 100% 100% 50% 50% 50%	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [15] Copay varies by service Copay varies by service (prior auth. required) 50% (ded waived) (prior auth. required)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [15] Copay varies by service Copay varies by service (prior auth. required) 50% (ded waived) (prior auth. required)

† HSA Qualified High Deductible Plan

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

1. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
2. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family
3. Maximum member responsibility.
4. Classified specialty drugs must obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
5. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.
6. See plan specific EOC for information on preventive services.
7. Evaluation only.
8. Limit one exam per 12 months
9. The four prescription drug tiers are: tier 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
10. Medical emergency only.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
16. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
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.

Additional Footnotes

Groups Beginning 7/1/20

Gold HMO

(Footnotes continued from page 26)

12. 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.
13. 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.
14. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2020 plans. Cost sharing for non-essential health benefits or optional benefits elected by a group does not accrue to the deductible or OOPM.
15. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
16. Amount listed for In-Patient Services only.

Gold PPO

(Footnotes continued from page 36)

* 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 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold PPO

(Footnotes continued from page 34)

* 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 1 typically generic drugs; tier 2 typically preferred brand and non-preferred generics; tier 3 typically non-preferred brand drugs; tier 4 typically specialty (brand and generic) drugs.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.

Gold PPO

(Footnotes continued from page 38)

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.

Silver HMO

(Footnotes continued from page 52)

12. 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.
13. 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.
14. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
15. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.

Additional Footnotes

Groups Beginning 7/1/20

Silver PPO

(Footnotes continued from page 58)

* 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 1 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.

Silver PPO

(Footnotes continued from page 60)

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 HMO

(Footnotes continued from page 70)

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.
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.

Bronze HMO

(Footnotes continued from page 72)

9. Cost sharing applies 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 retail 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 $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
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 under age 19 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. 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.

Additional Footnotes

Groups Beginning 7/1/20

Bronze PPO

(Footnotes continued from page 76)

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

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