

Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4/1/16

Bronze



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

Bronze HMO & HSP

Groups Beginning 4/1/16

Services	HMO A	HMO B	HSP A
Participating Health Plans	Aetna	Aetna	Health Net
Network Name	HMO Deductible	Basic HMO	PureCare
Metal Tier	Bronze	Bronze	Bronze
Calendar Year Deductible*	\$5,500 / \$11,000 ⁸ (combined Med/Pediatric dental ded)(applies to Max OOP)	\$5,500 / \$11,000 ⁸ (combined Med/Pediatric dental ded) (applies to Max OOP)	\$4,000 / \$8,000 (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,600 / \$13,200 ⁹	\$6,600 / \$13,200 ⁹	\$6,850 / \$13,700
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	\$50 Copay (ded waived)	\$50 Copay (ded waived)	\$45 Copay ²
Specialist Visit (SPC)	\$75 Copay (ded waived)	\$75 Copay (ded waived)	\$60 Copay ²
Laboratory	\$50 Copay (ded waived)	\$50 Copay (ded waived)	50%
X-Ray	\$75 Copay (ded waived)	\$75 Copay (ded waived)	50%
MRI, CT and PET	\$500 Copay (ded waived)	\$500 Copay (ded waived)	50%
Hospital Services – In-Patient	50%	50%	50%
In-Patient Physician Fees	50%	50%	50%
Emergency Room (copay waived if admitted)	50%	50%	50%
Urgent Care	\$50 Copay (ded waived)	\$50 Copay (ded waived)	\$100 Copay
Hospital Services – Out-Patient			
Surgical Facility	50%	50%	50%
Ambulatory Surgery Center	50%	50%	50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	\$75 Copay (ded waived)	\$75 Copay (ded waived)	\$60 Copay
Ambulance Services (per trip)	\$150 Copay	\$150 Copay	50%
Rx Benefits			
Generic	\$35 Copay (ded waived) ⁵	\$35 Copay (ded waived) ⁵	\$15 Copay (ded waived)
Formulary Brand	\$250 Ded – \$75 Copay ⁵	\$250 Ded – \$75 Copay ⁵	\$45 Copay (combined Med/Rx ded)
Non-Formulary Brand	\$250 Ded – \$150 Copay ⁵	\$250 Ded – \$150 Copay ⁵	50% (combined Med/Rx ded)
Specialty	\$250 Ded – 70% (up to \$500 per prescription ¹²) ^{5,11}	\$250 Ded – 70% (up to \$500 per prescription ¹²) ^{5,11}	50% (combined Med/Rx ded)
Oral Contraceptives	100% (generic only)	100% (generic only)	100%
Diabetes – Self-Injectable	\$250 Ded – Applicable Rx Copay ⁵	\$250 Ded – Applicable Rx Copay ⁵	50% (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) ⁶	100% (ded waived) ⁶	100% (ded waived) ⁶
Chronic Disease Management	Covered as any Illness	Covered as any Illness	\$60 Copay
Chemotherapy	\$75 Copay (ded waived)	\$75 Copay (ded waived)	50%
Chiropractic (20 visits max per year)	\$15 Copay (ded waived)	\$15 Copay (ded waived)	Not Covered
Acupuncture	\$15 Copay (ded waived) ¹	\$15 Copay (ded waived) ¹	\$10 Copay
Physical, Occupational, Speech Therapy	\$50 Copay (ded waived)	\$50 Copay (ded waived)	\$45 Copay
Rehabilitative & Habilitative Services and Devices	\$50 Copay (ded waived)	\$50 Copay (ded waived)	\$45 Copay

Bronze HMO & HSP

Groups Beginning 4/1/16

Services	HMO A	HMO B	HSP A
Participating Health Plans	Aetna	Aetna	Health Net
Network Name	HMO Deductible	Basic HMO	PureCare
Metal Tier	Bronze	Bronze	Bronze
Home Health Care (Max 100 visits per year)	\$50 Copay	\$50 Copay	50%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50%	50%	50% (no limit)
Hospice	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	\$100 Copay	\$100 Copay	50%
Mental Health			
In-Patient	50%	50%	50%
Out-Patient	\$50 Copay (ded waived)	\$50 Copay (ded waived)	\$45 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	50%	50%	50%
Infertility			
Infertility Evaluation and Treatment	See Plan Specific EOC	See Plan Specific EOC	50% ³
Infertility Drugs	See Plan Specific EOC	See Plan Specific EOC	50% ³
In Vitro Fertilization (IVF)	Not covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Covered ¹⁰	Covered ¹⁰	50% ³
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	EyeMed	EyeMed	EyeMed ⁴
Network	EyeMed	EyeMed	EyeMed
Exam	\$50 Copay (ded waived)	\$50 Copay (ded waived)	100%
Contact Lenses	100% (Pref. Provider)	100% (Pref. Provider)	100%
Frames	100% (Pref. Provider)	100% (Pref. Provider)	1 pair per calendar year
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 pair per calendar year
Pediatric Dental			
Carrier	Aetna	Aetna	Dental Benefit Providers ^{4,7}
Network	PPO	PPO	Dental Benefit Providers
Deductible	Combined Med/Pediatric dental ded	Combined Med/Pediatric dental ded	None
Out-of-Pocket Maximum	\$1,000 / \$2,000	\$1,000 / \$2,000	None
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100%
Basic Services	70%	70%	\$25 Copay
Major Services (no waiting period)	50%	50%	\$300 Copay
Orthodontics (medically necessary)	50%	50%	\$1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Unlimited visits for treatment of nausea or as part of a comprehensive pain management program and for anesthesia.
2. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
3. Limited to a lifetime benefit maximum of \$8,500 for infertility services and \$1,500 for infertility drugs.
4. Pediatric dental and vision are included on all plans.
5. Pharmacy tiers are Tier 1: Preferred Generic, Tier 2: Preferred Brand, Tier 3: Non-Preferred Generic and Brand, Tier 4: Preferred and Non-Preferred Specialty.
6. See plan specific EOC for information on preventive services.
7. 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.

8. 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.
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. Effective 7.1.14 for New and Renewing Business – Limited to \$2,000 per member per lifetime.
11. First Prescription must be filled at a participating retail pharmacy or Aetna Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.
12. Maximum member responsibility.



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Bronze HMO

Groups Beginning 4/1/16

Services	HMO B	HMO C†	HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente		Sharp
Network Name	Full	Full		Premier
Metal Tier	Bronze	Bronze		Bronze
Calendar Year Deductible*	\$5,000 / \$10,000 ¹⁰ (applies to Max OOP)	\$4,500 / \$9,000 (combined Med/ Rx ded)(applies to Max OOP)		\$2,650 / \$5,300 ⁴ (combined Med/ Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,500 / \$13,000 ¹¹	\$6,500 / \$13,000		\$6,500 / \$13,000 ⁴
Lifetime Maximum	Unlimited	Unlimited		Unlimited
Dr. Office Visits (PCP)	\$60 Copay ¹²	75%		\$60 Copay
Specialist Visit (SPC)	\$60 Copay ¹²	75%		\$120 Copay
Laboratory	60%	75%		\$60 Copay
X-Ray	60%	75%		\$120 Copay
MRI, CT and PET	60% per procedure	75% per procedure		\$400 Copay per procedure
Hospital Services – In-Patient	60%	75%		\$1,500 Copay per day – 3 days max
In-Patient Physician Fees	60%	75%		100%
Emergency Room (copay waived if admitted)	60%	75%		\$500 Copay
Urgent Care	\$60 Copay ¹²	75%		\$120 Copay
Hospital Services – Out-Patient				
Surgical Facility	60%	75%		60%
Ambulatory Surgery Center	60%	75%		60%
Hospital Pre-Authorization	Required	Required		Required
2nd Surgical Opinion	\$60 Copay	75%		\$120 Copay
Ambulance Services (per trip)	60%	75%		\$500 Copay
Rx Benefits				
Generic	\$1,000 Ded – \$20 Copay	75% (combined Med/Rx ded)		\$19 Copay (ded waived)
Formulary Brand	\$1,000 Ded –\$50 Copay	75% (combined Med/Rx ded)		\$60 Copay (combined Med/Rx ded)
Non-Formulary Brand	\$1,000 Ded –\$50 Copay (with physician approval)	75% (combined Med/Rx ded) (with physician approval)		\$120 Copay (combined Med/Rx ded)
Specialty	\$1,000 Ded – 80% (up to \$250 per prescription ⁹) (with physician approval)	75% (up to \$250 per prescription ⁹) (combined Med/Rx ded) (with physician approval)		Applicable Rx Copay (combined Med/Rx ded)
Oral Contraceptives	100%	100%		100% (if in formulary)
Diabetes – Self-Injectable	\$1,000 ded – \$50 Copay	75%		Applicable Rx Copay (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) ⁵	100% (ded waived) ⁵		100% (ded waived) ⁵
Chronic Disease Management	\$60 Copay	75%		\$120 Copay
Chemotherapy	100%	100%		\$120 Copay ⁸
Chiropractic (20 visits max per year)	Not Covered	Not Covered		Not Covered
Acupuncture	\$60 Copay	75%		\$120 Copay
Physical, Occupational, Speech Therapy	\$60 Copay	75%		\$50 Copay
Rehabilitative & Habilitative Services and Devices	\$60 Copay	75%		\$50 Copay
Home Health Care (Max 100 visits per year)	100% ¹	100% ¹		\$120 Copay

Services	HMO B	HMO C [†]	HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente		Sharp
Network Name	Full	Full		Premier
Metal Tier	Bronze	Bronze		Bronze
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	75%		\$200 Copay per day
Hospice	100%	100%		100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	60% ⁶	75% ⁶		50%
Mental Health In-Patient Out-Patient	60% \$60 Copay ¹²	75% 75%		\$1,500 Copay per day – 3 days max \$120 Copay
Drug/Substance Abuse In-Patient (Detox Only)	60%	75%		\$1,500 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)	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 1 pair per calendar year (ded waived) None	Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) None		VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	Delta Dental DeltaCare USA None \$350 / \$700 100% (ded waived) 100% (ded waived) \$95 Copay ² \$365 Copay ³ \$350 Copay	Delta Dental DeltaCare USA None \$350 /\$700 100% (ded waived) 100% (ded waived) \$95 Copay ² \$365 Copay ³ \$350 Copay		Premier Access Access Dental DHMO None \$1,000 / \$2,000 ⁷ \$20 Copay 100% \$95 Copay ² \$365 Copay ³ \$1,000 Copay

† HSA Qualified High Deductible Plan

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

- Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
- DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
- DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
- Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
- See plan specific EOC information on preventive services.
- Effective 7.1.14 certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.

- The pediatric dental out-of-pocket maximum is \$1,000 for a family with one child and \$2,000 for a family with 2 or more children.
- Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
- Maximum member responsibility.
- Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
- Under a family contract, an insured can satisfy their individual out-of-pocket maximum, however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
- Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).



Bronze HMO

Groups Beginning 4/1/16

Services	HMO B† HSA Qualified	HMO C† HSA Qualified	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Full
Metal Tier	Bronze	Bronze	Bronze
Calendar Year Deductible*	\$3,850 / \$7,700 ¹⁵ (combined Med/Rx ded)(applies to Max OOP)	\$4,500 / \$9,000 ¹⁰ (combined Med/Rx ded) (applies to Max OOP)	\$6,000 / \$12,000 ¹ (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,500 / \$13,000 ¹⁵	\$6,250 / \$12,500 ¹⁰	\$6,500 / \$13,000 ²
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	60%	\$70 Copay ^{8,9}
Specialist Visit (SPC)	60%	60%	\$90 Copay ⁸
Laboratory	60%	60%	\$40 Copay (ded waived)
X-Ray	60%	60%	100% ¹⁹
MRI, CT and PET	60%	60%	100% ¹⁹
Hospital Services – In-Patient	60%	60%	100% ¹⁹
In-Patient Physician Fees	60%	60%	100% ¹⁹
Emergency Room (copay waived if admitted)	60%	60%	100% ¹⁹
Urgent Care	60%	60%	\$120 Copay ⁹
Hospital Services – Out-Patient			
Surgical Facility	60%	60%	100% ¹⁹
Ambulatory Surgery Center	60%	60%	100% ¹⁹
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	60%	\$90 Copay ⁸
Ambulance Services (per trip)	60%	60%	100% ¹⁹
Rx Benefits			
Generic	60% (combined Med/Rx ded)	60% (combined Med/Rx ded)	\$500/\$1,000 Ded – 100% ¹⁹ (up to \$500 per prescription ¹⁶) ³
Formulary Brand	60% (combined Med/Rx ded)	60% (combined Med/Rx ded)	\$500/\$1,000 Ded – 100% ¹⁹ (up to \$500 per prescription ¹⁶) ^{3,4}
Non-Formulary Brand	60% (combined Med/Rx ded)	60% (combined Med/Rx ded)	\$500/\$1,000 Ded – 100% ¹⁹ (up to \$500 per prescription ¹⁶) ^{3,4}
Specialty	60% (combined Med/Rx ded)	60% (combined Med/Rx ded)	\$500/\$1,000 Ded – 100% ¹⁹ (up to \$500 per prescription ¹⁶) ^{3,4}
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100% (ded waived)
Diabetes – Self-Injectable	60% (combined Med/Rx ded)	60% (combined Med/Rx ded)	\$500 / \$1,000 Ded – Applicable Rx Copay ^{3,4}
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) ⁵	100% (ded waived) ⁵	100% (ded waived) ⁵
Chronic Disease Management	60%	60%	Covered as any Illness
Chemotherapy	60% ¹¹	Variable ¹¹	100% ¹⁹
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	60%	60%	\$70 Copay ⁸
Physical, Occupational, Speech Therapy	60%	60%	\$70 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	60%	60%	\$70 Copay (ded waived)
Home Health Care (Max 100 visits per year)	60%	60%	100% ¹⁹

Services	HMO B [†] HSA Qualified	HMO C [†] HSA Qualified	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Performance	Premier	Full
Metal Tier	Bronze	Bronze	Bronze
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	100% ¹⁹
Hospice	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	50%	60%	100% ¹⁹
Mental Health			
In-Patient	60%	60%	100% ^{17,19}
Out-Patient	60%	60%	\$70 Copay ¹⁸
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	60%	100% ¹⁹
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	VSP	VSP
Network	VSP	VSP	Choice Network
Exam	100%	100%	100% (ded waived) ⁷
Contact Lenses	1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses	1 pair per year ⁸
Frames	100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)	1 pair per year
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Premier Access	Premier Access	Delta Dental
Network	Access Dental DHMO	Access Dental DHMO	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	\$1,000 / \$2,000 ¹⁴	\$1,000 / \$2,000 ¹⁴	Combined with Medical
Office Visit	\$20 Copay	\$20 Copay	Copay varies by service
Diagnostic & Preventative (D&P)	100%	100%	100% (ded waived)
Basic Services	\$95 Copay ¹²	\$95 Copay ¹²	\$25 copay
Major Services (no waiting period)	\$365 Copay ¹³	\$365 Copay ¹³	Copay varies by service
Orthodontics (medically necessary)	\$1,000 Copay	\$1,000 Copay	\$1,000 Copay

[†] HSA Qualified High Deductible Plan

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

- Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out-of-pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends. Charges for services subject to a deductible are based on SHP's contracted rate with the provider of service.
- Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
- Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Specialty medications are only available for a 30-day supply. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
- Sexual dysfunction medications are subject to prior authorization, have a 50% cost share, and are limited to 8 doses per 30-day supply.
- See plan specific EOC for information on preventive services.
- Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.

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

8. Deductible is waived for the first three non-preventive visits (combined for primary care, specialist, urgent care, acupuncture and outpatient mental health).

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

10. In high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.

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.

(Foot notes continued on page 16)



Bronze HMO

Groups Beginning 4/1/16

Services	HMO B [†] HSA Qualified	HMO A	HMO B [†] HSA Qualified
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	Focus	Alliance
Metal Tier	Bronze	Bronze	Bronze
Calendar Year Deductible*	\$4,500 / \$9,000 ³ (combined Med/Rx ded) (applies to Max OOP)	\$6,600 / \$13,200 ² (applies to Max OOP)	\$4,500 / \$9,000 ¹² (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,500 / \$13,000 ⁵	\$6,850 / \$13,700 ⁴	\$6,500 / \$13,000 ⁴
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60% ¹⁴	\$55 Copay (ded waived)	60%
Specialist Visit (SPC)	60%	\$85 Copay (ded waived)	60%
Laboratory	60%	\$25 Copay (ded waived)	60%
X-Ray	60%	\$25 Copay (ded waived)	60%
MRI, CT and PET	60%	\$250 Copay per procedure (ded waived)	60%
Hospital Services – In-Patient	60%	100%	60%
In-Patient Physician Fees	60%	100%	60%
Emergency Room (copay waived if admitted)	60%	100%	60%
Urgent Care	60%	\$150 Copay (ded waived)	60%
Hospital Services – Out-Patient			
Surgical Facility	60%	100%	60%
Ambulatory Surgery Center	60%	100%	60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	\$85 Copay (ded waived)	60%
Ambulance Services (per trip)	60%	\$100 Copay (ded waived)	60%
Rx Benefits			
Generic	60% (combined Med/Rx ded) ¹⁰	\$25 Copay (ded waived)	\$20 Copay (combined Med/Rx/Pediatric dental ded)
Formulary Brand	60% (combined Med/Rx ded) ^{10,11}	\$250 / \$500 Ded – \$50 Copay ⁶	\$50 Copay (combined Med/Rx/Pediatric dental ded) ⁶
Non-Formulary Brand	60% (combined Med/Rx ded) ^{10,11}	\$250 / \$500 Ded – \$125 Copay ⁶	\$100 Copay (combined Med/Rx/Pediatric dental ded) ⁶
Specialty	60% (combined Med/Rx ded) ^{10,11}	\$250 / \$500 Ded – 50% (up to \$300 per prescription ⁹) ⁶	75% (up to \$300 per prescription ⁹) (combined Med/Rx/Pediatric dental ded) ⁶
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	60% (combined Med/Rx ded) ^{10,11}	\$250 / \$500 Ded – Applicable Rx Copay ⁶	Applicable Rx Copay (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	60%	\$150 Copay ⁷	60%
Chiropractic (20 visits max per year)	Not Covered	\$15 Copay (ded waived)	\$15 Copay
Acupuncture	60%	\$10 Copay (ded waived)	60%
Physical, Occupational, Speech Therapy	60%	\$55 Copay (ded waived)	60%
Rehabilitative & Habilitative Services and Devices	60%	\$55 Copay (ded waived)	60%

Services	HMO B [†] HSA Qualified	HMO A	HMO B [†] HSA Qualified
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	Focus	Alliance
Metal Tier	Bronze	Bronze	Bronze
Home Health Care (Max 100 visits per year)	60%	\$50 Copay (ded waived)	60%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100%	60%
Hospice	100%	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	60%	\$50 Copay (ded waived)	60%
Mental Health			
In-Patient	60%	100%	60%
Out-Patient	60%	\$40 Copay (ded waived)	60%
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	100%	60%
Infertility			
Infertility Evaluation and Treatment	Not Covered	50% (ded waived)	50%
Infertility Drugs	Not Covered	See Plan Specific EOC	See Plan Specific EOC
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	50% (ded waived) ⁸	50% ⁸
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	Choice Network	Spectera Eyecare Networks	Spectera Eyecare Networks
Exam	100% (ded waived) ¹²	100% (ded waived)	100% (ded waived)
Contact Lenses	1 pair per year ¹³	100% (ded waived)	60%
Frames	1 pair per year	100% (ded waived)	60%
Maximum Allowance per year	None	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	Delta Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	DeltaCare USA	CA DHMO	CA DHMO
Deductible	None	None	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	Copay varies by service	100% (ded waived)	100% (ded waived)
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	\$25 copay	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	\$1,000 Copay	\$1,000 Copay	\$1,000 Copay

[†] HSA Qualified High Deductible Plan

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

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

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

3. Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high-deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments, and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the family deductible or out-of-pocket maximum. The family deductible amount may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out-of-pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. Under HDHP HSA plans, each family member is responsible for an individual deductible equal to the "self-only" or "single" enrollment amount or \$2600 (the IRS minimum deductible for family HSA-eligible plans), whichever is greater, until the family as a whole meets the family deductible. Medical or prescription services may be subject to a deductible as indicated within each benefit plan's services listing. The member must pay for these services when services are rendered until the deductible is met in that plan year. Charges for services subject to a deductible are based on SHP's contracted rate with the provider of service.

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

5. Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum.

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

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

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

9. Maximum member responsibility.

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

(Foot notes continued on page 16)



Bronze HMO

Groups Beginning 4/1/16

Services	HMO A [†] HSA Qualified	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	Bronze	Bronze	Bronze
Calendar Year Deductible*	\$4,000 / \$8,000 ^{1,7} (applies to Max OOP)	\$6,000 / \$12,000 ^{1,7} (applies to Max OOP)	\$6,000 / \$12,000 ^{1,7} (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	\$6,350 / \$12,700 ²	\$6,500 / \$13,000 ²	\$6,000 / \$12,000 ²
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60% ^{1,4}	\$70 Copay ⁹	100% ¹
Specialist Visit (SPC)	60% ^{1,4}	\$90 Copay ⁹	100% ¹
Laboratory	60% ^{1,4}	\$40 Copay (ded waived)	100% ¹
X-Ray	60% ^{1,4}	100% ^{1,11}	100% ¹
MRI, CT and PET	60% ^{1,4}	100% ^{1,11}	100% ¹
Hospital Services – In-Patient	60% ^{1,4}	100% ^{1,11}	100% ¹
In-Patient Physician Fees	60% ^{1,4}	100% ^{1,11}	100% ¹
Emergency Room (copay waived if admitted)	60% ^{1,4}	100% ^{1,11}	100% ¹
Urgent Care	60% ^{1,4}	\$120 Copay ¹	100% ¹
Hospital Services – Out-Patient			
Surgical Facility	60% ^{1,4}	100% ^{1,11}	100% ¹
Ambulatory Surgery Center	60% ^{1,4}	100% ^{1,11}	100% ¹
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60% ^{1,4}	\$90 Copay ⁹	100% ¹
Ambulance Services (per trip)	60% ^{1,4}	100% ^{1,11}	100% ¹
Rx Benefits			
Generic	60% ^{1,4}	\$500 /\$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁹) ¹	100% ¹ (combined Med/Rx ded)
Formulary Brand	60% ^{1,4}	\$500 /\$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁹) ¹	100% ¹ (combined Med/Rx ded)
Non-Formulary Brand	60% ^{1,4}	\$500 /\$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁹) ¹	100% ¹ (combined Med/Rx ded)
Specialty	60% ^{1,4}	\$500 /\$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁹) ¹	100% ¹ (combined Med/Rx ded)
Oral Contraceptives	100%	100% (ded waived)	100% ¹ (combined Med/Rx ded)
Diabetes – Self-Injectable	60% ^{1,4}	\$500 / \$1,000 Ded – 100% ¹¹ (up to \$500 per prescription ⁹) ¹	100% ¹ (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) ^{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	60% ^{1,4}	100% ^{1,11}	100% ¹
Chiropractic (20 visits max per year)	Not Covered	\$15 Copay (ded waived)	Not Covered
Acupuncture	\$15 Copay	\$15 Copay ⁹	100% ¹
Physical, Occupational, Speech Therapy	60% ^{1,4}	\$70 Copay (ded waived)	100% ¹
Rehabilitative & Habilitative Services and Devices	60% ^{1,4}	\$70 Copay (ded waived)	100% ¹
Home Health Care (Max 100 visits per year)	60% ^{1,4}	100% ^{1,11}	100% ¹

Services	HMO A [†] HSA Qualified	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	Bronze	Bronze	Bronze
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% ^{1,4}	100% ^{1,11}	100% ¹
Hospice	100% ¹	100% (ded waived)	100% ¹
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	60% ^{1,4,5}	100% ^{1,5,11}	100% ¹
Mental Health			
In-Patient	60% ^{1,4}	100% ^{1,11}	100% ¹
Out-Patient	60% ^{1,4}	\$70 Copay ⁹	100% ¹
Drug/Substance Abuse			
In-Patient (Detox Only)	60% ^{1,4}	100% ^{1,11}	100% ¹
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	MES Vision	MES Vision	MES Vision
Network	Eyewear Only	Eyewear Only	Eyewear Only
Exam	100% (ded waived)	100% (ded waived)	100% (ded waived)
Contact Lenses	100%	100% (ded waived)	100% (ded waived)
Frames	100% (ded waived)	100% (ded waived)	100% (ded waived)
Maximum Allowance per year	1 per calendar year ¹⁰	1 per calendar year ¹⁰	1 per calendar year ¹⁰
Pediatric Dental			
Carrier	Access Dental	Access Dental	Access Dental
Network	Full	Full	Full
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	\$1,000 Copay	\$1,000 Copay	\$1,000 Copay

† 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. 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.
8. Maximum member responsibility.
9. Deductible waived for first three non-preventive care visits.
10. Limited to one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.
11. Covered in full after out-of-pocket maximum is met.



Bronze HMO

Groups Beginning 4/1/16

Services	HMO D [†]	HSA Qualified
Participating Health Plans	Western Health Advantage	
Network Name	Full	
Metal Tier	Bronze	
Calendar Year Deductible*	\$4,500 / \$9,000 ^{1,7} (combined Med/Rx ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$6,500 / \$13,000 ²	
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	60% ^{1,4}	
Specialist Visit (SPC)	60% ^{1,4}	
Laboratory	60% ^{1,4}	
X-Ray	60% ^{1,4}	
MRI, CT and PET	60% ^{1,4}	
Hospital Services – In-Patient	60% ^{1,4}	
In-Patient Physician Fees	60% ^{1,4}	
Emergency Room (copay waived if admitted)	60% ^{1,4}	
Urgent Care	60% ^{1,4}	
Hospital Services – Out-Patient		
Surgical Facility	60% ^{1,4}	
Ambulatory Surgery Center	60% ^{1,4}	
Hospital Pre-Authorization	Required	
2nd Surgical Opinion	60% ^{1,4}	
Ambulance Services (per trip)	60% ^{1,4}	
Rx Benefits		
Generic	60% ^{1,4} (combined Med/Rx ded)	
Formulary Brand	60% ^{1,4} (combined Med/Rx ded)	
Non-Formulary Brand	60% ^{1,4} (combined Med/Rx ded)	
Specialty	60% ^{1,4} (combined Med/Rx ded)	
Oral Contraceptives	100% (ded waived)	
Diabetes – Self-Injectable	60% ^{1,4} (combined Med/Rx ded)	
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any illness	
Preventive/Wellness Services	100% (ded waived) ^{3,6}	
Chronic Disease Management	Covered as any illness	
Chemotherapy	60% ^{1,4}	
Chiropractic (20 visits max per year)	Not Covered	
Acupuncture	60% ^{1,4}	
Physical, Occupational, Speech Therapy	60% ^{1,4}	
Rehabilitative & Habilitative Services and Devices	60% ^{1,4}	

Services	HMO D [†]	HSA Qualified
Participating Health Plans	Western Health Advantage	
Network Name	Full	
Metal Tier	Bronze	
Home Health Care (Max 100 visits per year)	60% ^{1,4}	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% ^{1,4}	
Hospice	100% ¹	
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	60% ^{1,4,5}	
Mental Health		
In-Patient	60% ^{1,4}	
Out-Patient	60% ^{1,4}	
Drug/Substance Abuse		
In-Patient (Detox Only)	60% ^{1,4}	
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 ⁸	
Pediatric Dental		
Carrier	Access Dental	
Network	Full	
Deductible	None	
Out-of-Pocket Maximum	Combined with Medical	
Office Visit	100%	
Diagnostic & Preventative (D&P)	100% (ded waived)	
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. 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. 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.

8. Limited to one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.



Bronze EPO

Groups Beginning 4/1/16

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	Bronze	Bronze	
Calendar Year Deductible*	\$5,600 / \$11,200 ¹ (combined Med/Pediatric dental ded) (applies to Max OOP)	\$5,000 / \$10,000 ¹ (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	
Out-of-Pocket Max Ind/Fam	\$6,850 / \$13,700 ²	\$6,500 / \$13,000 ²	
Lifetime Maximum	Unlimited	Unlimited	
Dr. Office Visits (PCP)	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	
Specialist Visit (SPC)	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	
Laboratory	60%	80%	
X-Ray	60%	80%	
MRI, CT and PET	60%	80%	
Hospital Services – In-Patient	\$1,000 Copay	80%	
In-Patient Physician Fees	60%	80%	
Emergency Room (copay waived if admitted)	\$400 Copay	80%	
Urgent Care	60%	80%	
Hospital Services – Out-Patient			
Surgical Facility	\$500 Copay	80%	
Ambulatory Surgery Center	\$500 Copay	80%	
Hospital Pre-Authorization	Required	Required	
2nd Surgical Opinion	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	
Ambulance Services (per trip)	60%	80%	
Rx Benefits			
Generic	\$19 Copay (ded waived)	80% (combined Med/Rx/Pediatric dental ded)	
Formulary Brand	\$750 / \$1,500 Ded – \$50 Copay	80% (combined Med/Rx/Pediatric dental ded)	
Non-Formulary Brand	\$750 / \$1,500 Ded – \$90 Copay	80% (combined Med/Rx/Pediatric dental ded)	
Specialty	\$750 / \$1,500 Ded – 70% (up to \$500 per prescription ³) ⁴	80% (combined Med/Rx/Pediatric dental ded)	
Oral Contraceptives	100%	100%	
Diabetes – Self-Injectable	\$750 / \$1,500 Ded – Applicable Rx Copay	80% (combined Med/Rx/Pediatric dental ded)	
Pre-Existing Conditions	Covered	Covered	
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) ⁶	100% (ded waived) ⁶	
Chronic Disease Management	Covered as any Illness	Covered as any Illness	
Chemotherapy	60%	80%	
Chiropractic (20 visits max per year)	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	
Acupuncture	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	
Physical, Occupational, Speech Therapy	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	
Rehabilitative & Habilitative Services and Devices	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	

Services	EPO A	EPO B [†]	HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	Prudent Buyer – Small Group	
Metal Tier	Bronze	Bronze	
Home Health Care (Max 100 visits per year)	60% ⁵	80% ⁵	
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	\$1,000 Copay	80% (100 days max per year)	
Hospice	100%	100%	
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	60%	80%	
Mental Health			
In-Patient	\$1,000 Copay	80%	
Out-Patient	\$65 Copay (first 3 visits) ^{8,9} – 60%	80%	
Drug/Substance Abuse			
In-Patient (Detox Only)	\$1,000 Copay	80%	
Infertility			
Infertility Evaluation and Treatment	\$65 Copay (first 3 visits) ^{8,9} – 60% ⁷	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	Anthem Vision	Anthem Vision	
Network	Blue View Vision	Blue View Vision	
Exam	100% (ded waived)	100% (ded waived)	
Contact Lenses	1 pair per calendar year	100% (in lieu of eyeglasses)	
Frames	1 pair per calendar year (ded waived)	100% (ded waived)	
Maximum Allowance per year	1 per calendar year	1 pair per calendar year	
Pediatric Dental			
Carrier	Anthem Dental	Anthem dental	
Network	Prime	Prime	
Deductible	Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded	
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	
Office Visit	100%	100%	
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	
Basic Services	50%	50%	
Major Services (no waiting period)	50%	50%	
Orthodontics (medically necessary)	50%	50%	

† HSA Qualified High Deductible Plan

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

- Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
- Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
- Maximum member responsibility.
- Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
- Limited to 100 4-hour visits per year.
- See plan specific EOC for information on preventive services.
- Evaluation only.

- Office Visits are per Member and combined for PCP, SCP, Retail Health Clinic Visit, Online Visit, Counseling (including Family Planning, Nutritional, Diabetes Education), Chiropractic/Osteopathic/Manipulation Therapy, Physical/Occupational Therapy, Speech Therapy, Cardiac Rehabilitation, Pulmonary Therapy, Acupuncture, Mental Health and Substance Abuse, and Telehealth. These Office Visits have a Copayment which applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance instead of a Copayment. Always check the setting above to determine your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment/Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
- Deductible is waived for the first three visits combined.



Bronze HMO

Groups Beginning 4/1/16

(Foot notes continued from page 7)

14. The pediatric dental out-of-pocket maximum is \$1,000 for a family with one child and \$2,000 for a family with 2 or more children
15. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
15. Maximum member responsibility.
17. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
18. Mental/Behavioral Health/SUD Other Outpatient Services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism.
19. Covered in full after out-of-pocket maximum is met.

(Foot notes continued from page 9)

11. Sexual dysfunction medications are subject to prior authorization, have a 50% cost share, and are limited to 8 doses per 30-day supply.
12. 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.
13. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
14. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
15. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
16. Mental/Behavioral Health/SUD Other Outpatient Services include: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism.

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