Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4/1/16

Gold

CaliforniaChoice®
Your Health. Your Choice.®

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

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Groups Beginning 4/1/16

The benefits listed in this brochure were collected from all plans participating in the California*Choice*® *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.*

Gold HMO

Groups Beginning 4/1/16

Services	HMO A	HMO B	HMO A
Participating Health Plans	Aetna	Aetna	Anthem Blue Cross
Network Name	Aetna Value Network	Aetna Value Network	Select HMO
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible *	None	None	None
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000 [4]	$6,000 / $12,000 [4]	$6,850 / $13,700 [4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$30 Copay	$50 Copay
Specialist Visit (SPC)	$60 Copay	$60 Copay	$100 Copay
Laboratory	$20 Copay	$30 Copay	100%
X-Ray	$60 Copay	$30 Copay	100%
MRI, CT and PET	$250 Copay	$250 Copay	$100 Copay per test
Hospital Services – In-Patient	$750 Copay	$500 Copay per day – 5 days max	$750 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay	$350 Copay
Urgent Care	$50 Copay	$50 Copay	$100 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $600 Copay $400 Copay	 $600 Copay $400 Copay	 $500 Copay $500 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay	$60 Copay	$100 Copay
Ambulance Services (per trip)	$150 Copay	$150 Copay	70%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [2] $250 Ded – $50 Copay [2] $250 Ded – $100 Copay [2] $250 Ded – 70% (up to $500 per prescription [10]) [2, 7]	 $20 Copay (ded waived) [2] $250 Ded – $50 Copay [2] $250 Ded – $70 Copay [2] $250 Ded – 70% (up to $500 per prescription [10]) [2, 7]	 $15 Copay (ded waived) $250 / $500 Ded – $50 Copay $250 / $500 Ded – $90 Copay $250 / $500 Ded – 75% (up to $250 per prescription [10]) [8]
Oral Contraceptives	100% (generic only)	100% (generic only)	100%
Diabetes – Self-Injectable	$250 Ded – Applicable Rx Copay [2]	$250 Ded – Applicable Rx Copay [2]	$250 / $500 Ded – Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3]	100% [3]	100% [3]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$60 Copay	$60 Copay	$100 Copay
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$50 Copay
Acupuncture	$15 Copay [1]	$15 Copay [1]	$50 Copay
Physical, Occupational, Speech Therapy	$60 Copay	$60 Copay	$50 Copay
Rehabilitative & Habilitative Services and Devices	$60 Copay	$60 Copay	$50 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$30 Copay	$50 Copay [5]

Services	HMO A	HMO B	HMO A
Participating Health Plans	Aetna	Aetna	Anthem Blue Cross
Network Name	Aetna Value Network	Aetna Value Network	Select HMO
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$750 Copay	$500 Copay per day – 5 days max	100% (100 days max per year)
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80%	80%	70%
Mental Health In-Patient Out-Patient	 $750 Copay $60 Copay	 $500 Copay per day – 5 days max $60 Copay	 $750 Copay per day – 4 days max $50 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $750 Copay	 $500 Copay per day – 5 days max	 $750 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)	 See Plan Specific EOC See Plan Specific EOC Not Covered Covered [6] Not Covered	 See Plan Specific EOC See Plan Specific EOC Not Covered Covered [6] Not Covered	 $50 Copay [9] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed EyeMed $20 Copay 100% (Pref. Provider) 100% (Pref. Provider) 1 per calendar year	 EyeMed EyeMed $30 Copay 100% (Pref. Provider) 100% (Pref. Provider) 1 per calendar year	 Anthem Vision Blue View Vision 100% 100% (in lieu of eyeglasses) 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)	 Aetna PPO None $1,000 / $2,000 100% 100% 70% 50% 50%	 Aetna PPO None $1,000 / $2,000 100% 100% 70% 50% 50%	 Anthem Dental Prime None Combined with Medical 100% 100% 50% 50% 50%

* 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. 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.
3. See plan specific EOC for information on preventive services.
4. 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.
5. Limited to 100 4-hour visits per year.
6. Effective 7.1.14 for New and Renewing Business - Limited to $2,000 per member per lifetime.
7. First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.
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.

Gold HMO & HSP

Groups Beginning 4/1/16

Services	HMO A	HMO B	HSP A
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	PureCare
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$500 / $1,000 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,500 / $11,000	$5,500 / $11,000	$6,850 / $13,700
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay	$40 Copay	$3 Copay [10]
Specialist Visit (SPC)	$50 Copay	$40 Copay	$15 Copay [10]
Laboratory	$40 Copay	$40 Copay	$15 Copay
X-Ray	$40 Copay	$40 Copay	$15 Copay
MRI, CT and PET	$150 Copay per procedure	$150 Copay per procedure	$300 Copay per procedure
Hospital Services – In-Patient	$600 Copay per day – 4 days max	60%	50%
In-Patient Physician Fees	100%	100%	50%
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay	50%
Urgent Care	$40 Copay	$40 Copay	$100 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $600 Copay $600 Copay	 60% 60%	 50% 50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$40 Copay	$15 Copay
Ambulance Services (per trip)	$200 Copay	$200 Copay	50%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) [5, 7] $200 Ded – $30 Copay [5, 6, 7] $200 Ded – $50 Copay [5, 6, 7] $200 Ded – 70% (prior auth. required) [5, 6, 7]	 $20 Copay (ded waived) [5, 7] $200 Ded – $30 Copay [5, 6, 7] $200 Ded – $50 Copay [5, 6, 7] $200 Ded – 70% (prior auth. required) [5, 6, 7]	 $5 Copay (overall ded waived) $30 Copay (overall ded waived) 50% (overall ded waived) 50% (overall ded waived)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	$200 Ded – Applicable Rx Copay [5, 6, 7]	$200 Ded – Applicable Rx Copay [5, 6, 7]	50% (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [3]	100% [3]	100% (ded waived) [3]
Chronic Disease Management	$50 Copay	$40 Copay	$15 Copay
Chemotherapy	100%	100%	50%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay [1]	$10 Copay [1]	$3 Copay
Physical, Occupational, Speech Therapy	$40 Copay	$40 Copay	$3 Copay
Rehabilitative & Habilitative Services and Devices	$40 Copay	$40 Copay	$3 Copay
Home Health Care (Max 100 visits per year)	$50 Copay	$50 Copay	50%

Services	HMO A	HMO B	HSP A
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	PureCare
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$600 Copay per day – 4 days max (no limit)	60% (no limit)	50% (no limit)
Hospice	100%	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	70%	70%	50%
Mental Health In-Patient Out-Patient	 $600 Copay per day [4] – 4 days max $40 Copay [4]	 60% [4] $40 Copay [4]	 50% $3 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $600 Copay per day – 4 days max	 60%	 50%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% [2] 50% [2] Not Covered 50% [2] Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 50% [2] 50% [2] Not Covered 50% [2] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None	 EyeMed [9] EyeMed 100% 100% 1 pair per calendar year None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% $25 Copay $300 Copay $1,000 Copay	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% $25 Copay $300 Copay $1,000 Copay	 Dental Benefit Providers [8, 9] Dental Benefit Providers None Combined with Medical 100% 100% $25 Copay $300 Copay $1,000 Copay

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

1. Must be medically necessary.
2. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
3. See plan specific EOC for information on preventive services.
4. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
5. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
6. The brand-name prescription drug deductible (per member, per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs.
7. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
8. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
9. Pediatric dental and vision are included on all plans.
10. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.

Gold HMO

Groups Beginning 4/1/16

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Performance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$500 / $1,000 [6] (applies to Max OOP)	None	None
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000 [7]	$6,000 / $12,000	$6,500 / $13,000 [4]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay (ded waived)	$30 Copay	$20 Copay
Specialist Visit (SPC)	$25 Copay (ded waived)	$30 Copay	$50 Copay
Laboratory	$25 Copay (ded waived)	$40 Copay	100%
X-Ray	$25 Copay (ded waived)	$50 Copay	100%
MRI, CT and PET	$150 Copay per procedure (ded waived)	$250 Copay per procedure	$175 Copay per procedure
Hospital Services – In-Patient	$600 Copay per day – 5 days max	$600 Copay per day – 5 days max	75%
In-Patient Physician Fees	100%	100%	75%
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay	75%
Urgent Care	$25 Copay (ded waived)	$30 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $600 Copay $600 Copay	 $600 Copay $600 Copay	 75% 75%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$25 Copay	$30 Copay	$50 Copay
Ambulance Services (per trip)	$250 Copay	$250 Copay	75%
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)	 $15 Copay $50 Copay $50 Copay (with physician approval) 80% (up to $250 per prescription [11]) (with physician approval)	 $19 Copay (ded waived) $150 / $300 Ded – $35 Copay $150 / $300 Ded – $70 Copay $150 / $300 Ded – Applicable Rx Copay
Oral Contraceptives	100%	100%	100% (if in formulary)
Diabetes – Self-Injectable	$50 Copay (overall ded waived)	$50 Copay	$150 / $300 Ded – Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [5]	100% [5]	100% [5]
Chronic Disease Management	$25 Copay	$50 Copay	$50 Copay
Chemotherapy	100% (ded waived)	100%	$50 Copay [10]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$30 Copay (ded waived)	$30 Copay	$50 Copay
Physical, Occupational, Speech Therapy	$25 Copay (ded waived)	$30 Copay	$50 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay (ded waived)	$30 Copay	$50 Copay
Home Health Care (Max 100 visits per year)	100% (ded waived) [1]	100% [1]	$50 Copay

Services	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Performance
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max	$300 Copay per day – 5 days max	75%
Hospice	100% (ded waived)	100%	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80% (ded waived) [8]	80% [8]	50%
Mental Health In-Patient Out-Patient	 $600 Copay per day – 5 days max $25 Copay (ded waived)	 $600 Copay per day – 5 days max $30 Copay	 75% $50 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $600 Copay per day – 5 days max	 $600 Copay per day – 5 days max	 75%
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% 1 pair per calendar year 1 pair per calendar year None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $40 Copay [2] $365 Copay [3] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [2] $365 Copay [3] $350 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000 [9] $20 Copay 100% $95 Copay [2] $365 Copay [3] $1,000 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. 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.
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. 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.
9. 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.
10. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
11. Maximum member responsibility.

Gold HMO

Groups Beginning 4/1/16

Services	HMO B	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$1,500 / $3,000[7] (applies to Max OOP)	None
Out-of-Pocket Max Ind/Fam	$6,350 / $12,700[3]	$2,500 / $5,000[8]	$6,200 / $12,400[8]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$30 Copay[13]	$35 Copay[13]
Specialist Visit (SPC)	$60 Copay	$30 Copay	$55 Copay
Laboratory	$25 Copay	$30 Copay	$35 Copay
X-Ray	$60 Copay	$30 Copay	$50 Copay
MRI, CT and PET	$175 Copay per procedure	$50 Copay	$250 Copay
Hospital Services – In-Patient	$450 Copay per day – 5 days max	80%	$600 Copay per day – 5 days max
In-Patient Physician Fees	100%	80%	$55 Copay
Emergency Room (copay waived if admitted)	$200 Copay	$150 Copay	$250 Copay
Urgent Care	$60 Copay	$30 Copay	$60 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 75% 75%	 80% 80%	 $600 Copay $600 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay	$30 Copay	$55 Copay
Ambulance Services (per trip)	$200 Copay	$150 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $19 Copay (ded waived) $150 / $300 Ded – $35 Copay $150 / $300 Ded – $70 Copay $150 / $300 Ded – Applicable Rx Copay	 $5 Copay (overall ded waived)[9] $15 Copay (overall ded waived)[9, 10] $25 Copay (overall ded waived)[9, 10] 80% (up to $250 per prescription; overall ded waived[14])[9, 10]	 $15 Copay[9] $50 Copay[9, 10] $70 Copay[9, 10] 80% (up to $250 per prescription[14])[9, 10]
Oral Contraceptives	100% (if in formulary)	100% (overall ded waived)	100%
Diabetes – Self-Injectable	$150 / $300 Ded – Applicable Rx Copay	Applicable Rx Copay (overall ded waived)[9, 10]	Applicable Rx Copay[9, 10]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100%[4]	100% (ded waived)[4]	100%[4]
Chronic Disease Management	$60 Copay	Covered as any Illness	Covered as any Illness
Chemotherapy	$60 Copay[6]	80%	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$60 Copay	$30 Copay	$35 Copay
Physical, Occupational, Speech Therapy	$60 Copay	$30 Copay	$35 Copay
Rehabilitative & Habilitative Services and Devices	$60 Copay	$30 Copay	$35 Copay
Home Health Care (Max 100 visits per year)	$60 Copay	70%	$30 Copay

Services	HMO B	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay per day	80%	$300 Copay per day – 5 days max
Hospice	100%	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	50%	80%	80%
Mental Health In-Patient Out-Patient	 $450 Copay per day – 5 days max $60 Copay	 80% [15] $30 Copay [16]	 $600 Copay per day – 5 days max [15] $35 Copay [16]
Drug/Substance Abuse In-Patient (Detox Only)	 $450 Copay per day – 5 days max	 80%	 $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	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [11] 1 pair per year [12] 1 pair per year None	 VSP Choice Network 100% [11] 1 pair per year [12] 1 pair per 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)	 Premier Access Access Dental DHMO None $1,000 / $2,000 [5] $20 Copay 100% $95 Copay [1] $365 Copay [2] $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) $25 Copay Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% $25 Copay Copay varies by service $1,000 Copay

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

1. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
2. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. Individuals enrolled in a family plan will reach the annual deductible or out-of-pocket maximum if the member meets the individual deductible or out-of-pocket maximum amount or any combination of enrolled family members meets the family deductible or out-of-pocket maximum amount, whichever comes first. Amounts paid toward the deductible apply toward the out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental out-of-pocket maximum is $1,000 for a family with one child and $2,000 for a family with 2 or more children.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. 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.
8. Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
9. 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.
10. Sexual dysfunction medications are subject to prior authorization, have a 50% cost share, and 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. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
13. Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit.
14. Maximum member responsibility.
15. Inpatient Mental/Behavioral Health/SUD Services include: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
16. Mental/Behavioral Health/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.

Gold HMO

Groups Beginning 4/1/16

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$6,200 / $12,400 [1]	$5,000 / $10,000 [8]	$5,000 / $10,000 [8]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$35 Copay [7]	$30 Copay	$30 Copay
Specialist Visit (SPC)	$55 Copay	$50 Copay	$50 Copay
Laboratory	$35 Copay	$25 Copay	$25 Copay
X-Ray	$50 Copay	$25 Copay	$25 Copay
MRI, CT and PET	80%	$200 Copay per procedure	$200 Copay per procedure
Hospital Services – In-Patient	80%	70%	70%
In-Patient Physician Fees	80%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$300 Copay	$300 Copay
Urgent Care	$60 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 70% 70%	 70% 70%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$250 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [2] $50 Copay [2, 3] $70 Copay [2, 3] 80% (up to $250 per prescription [12]) [2, 3]	 $15 Copay $35 Copay [9] $70 Copay [9] 75% (up to $300 per prescription [12]) [9]	 $15 Copay $35 Copay [9] $70 Copay [9] 75% (up to $300 per prescription [12]) [9]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [2,3]	Applicable Rx Copay [9]	Applicable Rx Copay [9]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	80%	$150 Copay [10]	$150 Copay [10]
Chiropractic (20 visits max per year)	Not Covered	$15 Copay	$15 Copay
Acupuncture	$35 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$35 Copay	$30 Copay	$30 Copay
Rehabilitative & Habilitative Services and Devices	$35 Copay	$30 Copay	$30 Copay
Home Health Care (Max 100 visits per year)	80%	$30 Copay	$30 Copay

Services	HMO C	HMO A	HMO B
Participating Health Plans	Sutter Health Plus	UnitedHealthcare	UnitedHealthcare
Network Name	Full	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	70%	70%
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80%	$50 Copay	$50 Copay
Mental Health In-Patient Out-Patient	 80% [13] $35 Copay [14]	 70% $40 Copay	 70% $40 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 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	 50% See Plan Specific EOC Not Covered 50% [11] Not Covered	 50% See Plan Specific EOC Not Covered 50% [11] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% [5] 1 pair per year [6] 1 pair per year None	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% $25 Copay 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. Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
2. 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.
3. Sexual dysfunction medications are subject to prior authorization, have a 50% cost share, and 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.
6. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
7. 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.
8. 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.
9. For Specialty drugs, please see plan specific EOC.
10. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
11. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
12. Maximum member responsibility.
13. 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.
14. 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.

Gold HMO

Groups Beginning 4/1/16

Services	HMO C	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000 [6]	$6,350 / $12,700 [1]	$6,200 / $12,400 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$40 Copay	$35 Copay
Specialist Visit (SPC)	$50 Copay	$40 Copay	$55 Copay
Laboratory	$25 Copay	$40 Copay	$35 Copay
X-Ray	$25 Copay	$40 Copay	$50 Copay
MRI, CT and PET	$200 Copay per procedure	$250 Copay	$250 Copay
Hospital Services – In-Patient	70%	$600 Copay per day	$600 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%	$55 Copay
Emergency Room (copay waived if admitted)	$300 Copay	$250 Copay	$250 Copay
Urgent Care	$75 Copay	$100 Copay	$60 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 $250 Copay $250 Copay	 $600 Copay $600 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$40 Copay	$55 Copay
Ambulance Services (per trip)	$100 Copay	100%	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay $35 Copay [7] $70 Copay [7] 75% (up to $300 per prescription [10]) [7]	 $20 Copay $40 Copay $60 Copay 80% (up to $250 per 30 day supply [10]) [3]	 $15 Copay $50 Copay $70 Copay 80% (up to $250 per 30 day supply [10]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [7]	$40 Copay	$50 Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [5]	100% [2, 5]	100% [2, 5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [8]	$250 Copay	80%
Chiropractic (20 visits max per year)	$15 Copay	Not Covered	$15 Copay
Acupuncture	$10 Copay	$15 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$30 Copay	$40 Copay	$35 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay	$40 Copay	$35 Copay
Home Health Care (Max 100 visits per year)	$30 Copay	100%	$35 Copay

Services	HMO C	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	70%	$600 Copay per day	$300 Copay per day - Days 1-5
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	$50 Copay	80% [3, 4]	80% [3, 4]
Mental Health In-Patient Out-Patient	 70% $40 Copay	 $600 Copay per day $40 Copay	 $600 Copay per day – Days 1-5 $35 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 70%	 $600 Copay per day	 $600 Copay per day – Days 1-5
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% See Plan Specific EOC Not Covered 50% [9] Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% 70% 70% 1 per calendar year	 MES Vision Eyewear Only 100% 100% 100% 1 per calendar year [11]	 MES Vision Eyewear Only 100% 100% 100% 1 per calendar year [11]
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	 Access Dental Full None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Access Dental Full 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. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services (except infertility services) for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
7. For Specialty drugs, please see plan specific EOC.
8. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
9. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
10. Maximum member responsibility.
11. Limited to one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.

Gold PPO

Groups Beginning 4/1/16

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	In-Network	Out-of-Network
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $2,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$750 / $2,250 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,500 / $3,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$8,000 / $16,000 [1]	$4,000 / $8,000 [1]	$8,000 / $16,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$25 Copay (first 3 visits) [9,10] – 80%	50%	$25 Copay (ded waived)	50%
Specialist Visit (SPC)	$25 Copay (first 3 visits) [9,10] – 80%	50%	$50 Copay (ded waived)	50%
Laboratory	80%	50%	80%	50%
X-Ray	80%	50%	80%	50%
MRI, CT and PET	80%	50% (up to $800 per test) [5]	80%	50% (up to $800 per test) [5]
Hospital Services – In-Patient	Tier 1: 80% Tier 2: $500 Copay – 80%	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	80%		$200 Copay – 80%	
Urgent Care	80%	50%	$100 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 Tier 1: 80% Tier 2: $250 Copay – 80% Tier 1: 80% Tier 2: $250 Copay – 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 80% 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Required		Required	
2nd Surgical Opinion	$25 Copay (first 3 visits) [9,10] – 80%	50%	$50 Copay (ded waived)	50%
Ambulance Services (per trip)	80%		80%	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [2] $40 Copay [2] $80 Copay [2] 75% (up to $250 per prescription [8]) [2,6]		 $10 Copay (ded waived) [2] $250 / $500 Ded – $35 Copay [2] $250 / $500 Ded – $70 Copay [2] $250 / $500 Ded – 75% (up to $250 per prescription [8]) [2,6]	
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Rx Copay [2]		$250 / $500 Ded – Applicable Rx Copay [2]	
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%	80%	50%
Chiropractic (20 visits max per year)	$25 Copay (first 3 visits) [9,10] – 80%	50% (up to $25 per visit) [5]	$25 Copay (ded waived)	50% (up to $25 per visit) [5]
Acupuncture	$25 Copay (first 3 visits) [9,10] – 80%	50%	$25 Copay (ded waived)	50%
Physical, Occupational, Speech Therapy	$25 Copay (first 3 visits) [9,10] – 80%	50%	$25 Copay (ded waived)	50%
Rehabilitative & Habilitative Services and Devices	$25 Copay (first 3 visits) [9,10] – 80%	50%	$25 Copay (ded waived)	50%

Gold PPO

Groups Beginning 4/1/16

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	In-Network	Out-of-Network
Home Health Care (Max 100 visits per year)	80% [4]	50% (up to $75 per visit) [4, 5]	$25 Copay (ded waived) [4]	50% (up to $75 per visit) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 80% Tier 2: $500 Copay – 80% (100 days max per year)	50% (up to $150 per day) [5] (100 days max per year)	80% (100 days max per year)	50% (up to $150 per day) [5] (100 days max per year)
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80%	50%	80%	50%
Mental Health In-Patient Out-Patient	 Tier 1: 80% Tier 2: $500 Copay – 80% $25 Copay (first 3 visits) [9, 10] – 80%	 50% (up to $650 per day) [5] 50%	 80% $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 – 80%	 50% (up to $650 per day) [5]	 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)	 $25 Copay (first 3 visits) [9, 10] – 80% [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 $30 Reimbursement $60 Reimbursement (in lieu of eyeglasses) $45 Reimbursement (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 $30 Reimbursement $60 Reimbursement (in lieu of eyeglasses) $45 Reimbursement (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% (ded waived) 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%	 Anthem Dental Combined Med/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% (ded waived) 50% 50% 50%

* 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.

1. 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.
2. Benefits apply to prescriptions filled at participating pharmacies. Please see plan specific COI for non-participating pharmacy benefits.
3. See plan specific COI for information on preventive services.
4. Limited to 100 4-hour visits per year.
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. 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 determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
10. Deductible is waived for the first three visits combined.

Gold PPO

Groups Beginning 4/1/16

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	In-Network	Out-of-Network
Calendar Year Deductible*	$500 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $2,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,200 / $2,400 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,400 / $4,800 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$8,000 / $16,000 [1]	$3,500 / $7,000 [1]	$7,000 / $14,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$25 Copay (first 3 visits) [9, 10] – 80%	50%	$20 Copay (ded waived)	50%
Specialist Visit (SPC)	$25 Copay (first 3 visits) [9, 10] – 80%	50%	$40 Copay (ded waived)	50%
Laboratory	80%	50%	80%	50%
X-Ray	80%	50%	80%	50%
MRI, CT and PET	80%	50% (up to $800 per test) [5]	80%	50% (up to $800 per test) [5]
Hospital Services – In-Patient	$500 Copay	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
In-Patient Physician Fees	80%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay		$200 Copay – 80%	
Urgent Care	80%	50%	$100 Copay (ded waived)	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay $250 Copay	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 80% 80%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Required		Required	
2nd Surgical Opinion	$25 Copay (first 3 visits) [9, 10] – 80%	50%	$40 Copay (ded waived)	50%
Ambulance Services (per trip)	80%		80%	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay [2] $40 Copay [2] $80 Copay [2] 75% (up to $250 per prescription [8]) [2, 6]		 $15 Copay (ded waived) [2] $250 / $500 Ded – $40 Copay [2] $250 / $500 Ded – $80 Copay [2] $250 / $500 Ded – 70% (up to $500 per prescription [8]) [2, 6]	
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	Applicable Rx Copay [2]		$250 / $500 Ded – Applicable Rx Copay [2]	
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%	80%	50%
Chiropractic (20 visits max per year)	$25 Copay (first 3 visits) [9, 10] – 80%	50% (up to $25 per visit) [5]	$20 Copay (ded waived)	50% (up to $25 per visit) [5]
Acupuncture	$25 Copay (first 3 visits) [9, 10] – 80%	50%	$20 Copay (ded waived)	50%
Physical, Occupational, Speech Therapy	$25 Copay (first 3 visits) [9, 10] – 80%	50%	$20 Copay (ded waived)	50%
Rehabilitative & Habilitative Services and Devices	$25 Copay (first 3 visits) [9, 10] – 80%	50%	$20 Copay (ded waived)	50%
Home Health Care (Max 100 visits per year)	80% [4]	50% (up to $75 per visit) [4, 5]	$20 Copay (ded waived) [4]	50% (up to $75 per visit) [4, 5]

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	In-Network	Out-of-Network
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$500 Copay (100 days max per year)	50% (up to $150 per day) [5] (100 days max per year)	80% (100 days max per year)	50% (up to $150 per day) [5] (100 days max per year)
Hospice	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80%	50%	80%	50%
Mental Health				
In-Patient	$500 Copay	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
Out-Patient	$25 Copay (first 3 visits) [9,10] – 80%	50%	$20 Copay (ded waived)	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	$500 Copay	50% (up to $650 per day) [5]	80%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	$25 Copay (first 3 visits) [9,10] – 80% [7]	50% [7]	$20 Copay (ded waived) [7]	50% [7]
Infertility Drugs	Not Covered	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision				
Carrier	Anthem Vision	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision		Blue View Vision	
Exam	100% (ded waived)	$30 Reimbursement	100% (ded waived)	$30 Reimbursement
Contact Lenses	100% (in lieu of eyeglasses)	$60 Reimbursement (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	$60 Reimbursement (in lieu of eyeglasses)
Frames	100% (ded waived) (1 per calendar year)	$45 Reimbursement (1 per calendar year)	100% (ded waived) (1 per calendar year)	$45 Reimbursement (1 per calendar year)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental				
Carrier	Anthem Dental	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime		Prime	
Deductible	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)	Combined Med/Pediatric dental ded (IN & OON)
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%	100%	100%
Diagnostic &Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Basic Services	50%	50%	50%	50%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

* 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.

1. 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.
2. Benefits apply to prescriptions filled at participating pharmacies. Please see plan specific COI for non-participating pharmacy benefits.
3. See plan specific COI for information on preventive services.
4. Limited to 100 4-hour visits per year.
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. 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 determining your payment responsibility for other services and Providers, if applicable. Benefits are based on the setting in which Covered Services are received. If the service is available (and you obtain the service) in a setting other than the one listed above, your Copayment / Coinsurance will be based on the setting in which you receive the service. Please see those settings to determine your cost share.
10. Deductible is waived for the first three visits combined.

Gold EPO

Groups Beginning 4/1/16

Services	EPO A † HSA Qualified
Participating Health Plans	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group
Metal Tier	**Gold**
Calendar Year Deductible*	$2,600 / $4.000 [1] (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000 [2]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	80%
Specialist Visit (SPC)	80%
Laboratory	80%
X-Ray	80%
MRI, CT and PET	80%
Hospital Services – In-Patient	80%
In-Patient Physician Fees	80%
Emergency Room (copay waived if admitted)	80%
Urgent Care	80%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%
Hospital Pre-Authorization	Required
2nd Surgical Opinion	80%
Ambulance Services (per trip)	80%
Rx Benefits Generic Formulary BrandNon-Formulary Brand Specialty	 80% (combined Med/Rx/Pediatric dental ded) 80% (combined Med/Rx/Pediatric dental ded) 80% (combined Med/Rx/Pediatric dental ded) 80% (combined Med/Rx/Pediatric dental ded
Oral Contraceptives	100%
Diabetes – Self-Injectable	80% (combined Med/Rx/Pediatric dental ded)
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3]
Chronic Disease Management	Covered as any Illness
Chemotherapy	80%
Chiropractic (20 visits max per year)	80%
Acupuncture	80%
Physical, Occupational, Speech Therapy	80%

Services	EPO A † HSA Qualified
Participating Health Plans	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group
Metal Tier	**Gold**
Rehabilitative & Habilitative Services and Devices	80%
Home Health Care (Max 100 visits per year)	80% [4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% (100 days max per year)
Hospice	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80%
Mental Health In-Patient Out-Patient	 80% 80%
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)	 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) 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/Rx/Pediatric dental ded Combined with Medical 100% 100% (ded waived) 50% 50% 50%

† HSA Qualified High Deductible Plan.

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

1. 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.
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. See plan specific EOC for information on preventive services.
4. Limited to 100 4-hour visits per year.

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