Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4/1/16

Silver/Bronze

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.*

Silver HMO

Groups Beginning 4/1/16

Services	HMO A	HMO B	HMO A
Participating Health Plans	Aetna	Aetna	Anthem Blue Cross
Network Name	HMO Deductible	Basic HMO	Select HMO
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [4] (combined Med/ Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 [4] (combined Med/ Pediatric dental ded) (applies to Max OOP)	$1,750 / $3,500 / $8,000 [4] (combined Med/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000 [5]	$6,000 / $12,000 [5]	$6,850 / $13,700 [5]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$40 Copay (ded waived)	$50 Copay (ded waived)
Specialist Visit (SPC)	$60 Copay (ded waived)	$60 Copay (ded waived)	$75 Copay (ded waived)
Laboratory	$40 Copay (ded waived)	$40 Copay (ded waived)	$25 Copay (ded waived)
X-Ray	$40 Copay (ded waived)	$40 Copay (ded waived)	$25 Copay (ded waived)
MRI, CT and PET	$500 Copay (ded waived)	$500 Copay (ded waived)	$250 Copay per test (ded waived)
Hospital Services – In-Patient	$500 Copay per day – 3 days max	$500 Copay per day – 3 days max	60%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$300 Copay
Urgent Care	$50 Copay (ded waived)	$50 Copay (ded waived)	$100 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $750 Copay $600 Copay	 $750 Copay $600 Copay	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay (ded waived)	$60 Copay (ded waived)	$75 Copay (ded waived)
Ambulance Services (per trip)	$150 Copay	$150 Copay	60%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (overall ded waived) [2] $50 Copay (overall ded waived) [2] $70 Copay (overall ded waived) [2] 70% (up to $500 per prescription [11]) (overall ded waived) [2, 8]	 $15 Copay (overall ded waived) [2] $50 Copay (overall ded waived) [2] $70 Copay (overall ded waived) [2] 70% (up to $500 per prescription [11]) (overall ded waived) [2, 8]	 $15 Copay (ded waived) $250 / $500 Ded – $50 Copay $250 / $500 Ded – $90 Copay $250 / $500 Ded – 75% (up to $250 per prescription [11]) [9]
Oral Contraceptives	100% (generic only)	100% (generic only)	100%
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) [2]	Applicable Rx Copay (overall ded waived) [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% (ded waived) [3]	100% (ded waived) [3]	100% (ded waived) [3]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$60 Copay (ded waived)	$60 Copay (ded waived)	60% (ded waived)
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay (ded waived)	$50 Copay (ded waived)
Acupuncture	$15 Copay (ded waived) [1]	$15 Copay (ded waived) [1]	$50 Copay (ded waived)
Physical, Occupational, Speech Therapy	$60 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$40 Copay	$40 Copay	$50 Copay (ded waived) [6]

Services	HMO A	HMO B	HMO A
Participating Health Plans	Aetna	Aetna	Anthem Blue Cross
Network Name	HMO Deductible	Basic HMO	Select HMO
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$500 Copay per day – 3 days max	$500 Copay per day – 3 days max	60% (100 days max per year)
Hospice	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80%	80%	60%
Mental Health In-Patient Out-Patient	 $500 Copay per day – 3 days max $60 Copay (ded waived)	 $500 Copay per day – 3 days max $60 Copay (ded waived)	 60% $50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 $500 Copay per day – 3 days max	 $500 Copay per day – 3 days max	 60%
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 [7] Not Covered	 See Plan Specific EOC See Plan Specific EOC Not Covered Covered [7] Not Covered	 $50 Copay (ded waived) [10] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed EyeMed $40 Copay (ded waived) 100% (Pref. Provider) 100% (Pref. Provider) 1 per calendar year	 EyeMed EyeMed $40 Copay (ded waived) 100% (Pref. Provider) 100% (Pref. Provider) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year
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 Combined Med/Pediatric dental ded $1,000 / $2,000 100% 100% (ded waived) 70% 50% 50%	 Aetna PPO Combined Med/Pediatric dental ded $1,000 / $2,000 100% 100% (ded waived) 70% 50% 50%	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% (ded waived) 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, 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.
5. 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.
6. Limited to 100 4-hour visits per year.
7. Effective 7.1.14 for New and Renewing Business - Limited to $2,000 per member per lifetime.
8. First Prescription must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy®. Subsequent fills must be through Aetna Specialty Pharmacy®.
9. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
10. Evaluation only.
11. Maximum member responsibility.

Silver HMO & HSP

Groups Beginning 4/1/16

Services	HSP A	HMO B	HMO C
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,750 / $3,500 (applies to Max OOP)	$1,000 / $2,000[6] (applies to Max OOP)	$1,500 / $3,000[6] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700	$6,500 / $13,000[7]	$6,500 / $13,000[7]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay[4]	$40 Copay (ded waived)	$50 Copay (ded waived)
Specialist Visit (SPC)	$45 Copay[4]	$40 Copay (ded waived)	$50 Copay (ded waived)
Laboratory	$35 Copay	$50 Copay (ded waived)	$30 Copay (ded waived)
X-Ray	$35 Copay	$60 Copay (ded waived)	$50 Copay (ded waived)
MRI, CT and PET	$300 Copay per procedure	$250 Copay per procedure	$250 Copay per procedure
Hospital Services – In-Patient	50%	70%	80%
In-Patient Physician Fees	50%	70%	80%
Emergency Room (copay waived if admitted)	50%	70%	$250 Copay
Urgent Care	$100 Copay	$40 Copay (ded waived)	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 50% 50%	 70% 70%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$45 Copay	70%	80%
Ambulance Services (per trip)	50%	70%	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay (overall ded waived) $30 Copay (overall ded waived) 50% (overall ded waived) 50% (overall ded waived)	 $20 Copay (ded waived) $100 Ded – $50 Copay $100 Ded – $50 Copay (with physician approval) $100 Ded – 80% (up to $250 per prescription[13]) (with physician approval)	 $20 Copay (overall ded waived) $50 Copay (overall ded waived) $50 Copay (overall ded waived) (with physician approval) 80% (up to $250 per prescription[13]) (overall ded waived) (with physician approval)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	50% (overall ded waived)	$100 Ded – $50 Copay	$50 Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[5]	100% (ded waived)[5]	100% (ded waived)[5]
Chronic Disease Management	$45 Copay	$40 Copay	80%
Chemotherapy	50%	100% (ded waived)	100% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$10 Copay	$40 Copay (ded waived)	$50 Copay (ded waived)
Physical, Occupational, Speech Therapy	$30 Copay	$40 Copay (ded waived)	$50 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$30 Copay	$40 Copay (ded waived)	$50 Copay (ded waived)
Home Health Care (Max 100 visits per year)	50%	100% (ded waived)[1]	100% (ded waived)[1]

Services	HSP A	HMO B	HMO C
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	PureCare	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	50% (no limit)	70%	80%
Hospice	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	50%	70% (ded waived) [8]	80% (ded waived) [8]
Mental Health In-Patient Out-Patient	 50% $30 Copay	 70% $40 Copay (ded waived)	 80% $50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 50%	 70%	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% [9] 50% [9] 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	 EyeMed [10] EyeMed 100% 100% 1 pair per calendar year None	 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
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [10,11] Dental Benefit Providers None Combined with Medical 100% 100% $25 Copay $300 Copay $1,000 Copay	 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

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. Lower copay applies to office visits to Providers in family practice, pediatrics, internal medicine, geriatrics, general practice, obstetrics/gynecology and nurse practitioners. Higher copay applies to office visits to Providers in all other specialties.
5. See plan specific EOC for information on preventive services.
6. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
7. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
8. 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. Limited to a lifetime benefit maximum of $8,500 for infertility services and $1,500 for infertility drugs.
10. Pediatric dental and vision are included on all plans.
11. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.

Silver HMO

Groups Beginning 4/1/16

Services	HMO A	HMO B	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Premier	Performance	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,800 / $3,600 [2] (applies to Max OOP)	$1,800 / $3,600 [2] (applies to Max OOP)	$1,500 / $3,000 [7] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,000 / $12,000 [2]	$6,250 / $12,500 [2]	$6,500 / $13,000 [9]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay (ded waived)	$35 Copay (ded waived)	$45 Copay (ded waived) [13]
Specialist Visit (SPC)	$60 Copay (ded waived)	$70 Copay (ded waived)	$70 Copay (ded waived)
Laboratory	$30 Copay	$15 Copay	$35 Copay (ded waived)
X-Ray	$60 Copay	$30 Copay	$65 Copay (ded waived)
MRI, CT and PET	$250 Copay per procedure	$300 Copay per procedure	80%
Hospital Services – In-Patient	$750 Copay per day	70%	80%
In-Patient Physician Fees	100%	70%	80%
Emergency Room (copay waived if admitted)	$250 Copay	70%	$250 Copay
Urgent Care	$60 Copay (ded waived)	$70 Copay (ded waived)	$90 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 70% 70%	 70% 70%	 80% (ded waived) 80% (ded waived)
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$60 Copay (ded waived)	$70 Copay (ded waived)	$70 Copay (ded waived)
Ambulance Services (per trip)	$250 Copay (ded waived)	70% (ded waived)	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $19 Copay (ded waived) $200 / $400 Ded – $50 Copay $200 / $400 Ded – $80 Copay $200 / $400 Ded – Applicable Rx Copay	 $19 Copay (ded waived) $200 / $400 Ded – $50 Copay $200 / $400 Ded – $100 Copay $200 / $400 Ded – Applicable Rx Copay	 $15 Copay (ded waived) [9] $250 / $500 Ded - $55 Copay [9, 10] $250 / $500 Ded - $75 Copay [9, 10] $250 / $500 Ded - 80% (up to $250 per prescription [14]) [9, 10]
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100% (ded waived)
Diabetes – Self-Injectable	$200 / $400 Ded – Applicable Rx Copay	$200 / $400 Ded – Applicable Rx Copay	$250 / $500 Ded – 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% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	$60 Copay (ded waived)	$70 Copay (ded waived)	Covered as any Illness
Chemotherapy	$60 Copay [6]	$70 Copay [6]	80% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$60 Copay (ded waived)	$70 Copay (ded waived)	$45 Copay (ded waived)
Physical, Occupational, Speech Therapy	$50 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$50 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$60 Copay (ded waived)	$70 Copay (ded waived)	80% (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$200 Copay per day	70%	80%

Services	HMO A	HMO B	HMO A
Participating Health Plans	Sharp	Sharp	Sutter Health Plus
Network Name	Premier	Performance	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Hospice	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	50%	50%	80% (ded waived)
Mental Health In-Patient Out-Patient	 $750 Copay per day $60 Copay (ded waived)	 70% $70 Copay (ded waived)	 80% [15] $45 Copay (ded waived) [16]
Drug/Substance Abuse In-Patient (Detox Only)	 $750 Copay per day	 70%	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair In lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [11] 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 [3] $20 Copay 100% $95 Copay [4] $365 Copay [5] $1,000 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000 [3] $20 Copay 100% $95 Copay [4] $365 Copay [5] $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

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

1. See plan specific EOC for information on preventive services.
2. 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.
3. 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.
4. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
5. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. 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 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.

Silver HMO

Groups Beginning 4/1/16

Services	HMO B	HMO C† HSA Qualified	HMO D† HSA Qualified
Participating Health Plans	Sutter Health Plus	Sutter Health Plus	Sutter Health Plus
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,500 / $3,000 [1] (applies to Max OOP)	$2,600 / $4,000 [1, 10] (combined Med/Rx ded) (applies to Max OOP)	$2,600 / $4,000 [1, 10] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [2]	$4,500 / $9,000 [2]	$6,250 / $12,500 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay (ded waived) [8]	$35 Copay [8]	80% [8]
Specialist Visit (SPC)	$70 Copay (ded waived)	$35 Copay	80%
Laboratory	$35 Copay (ded waived)	$35 Copay	80%
X-Ray	$65 Copay (ded waived)	$15 Copay	80%
MRI, CT and PET	$250 Copay (ded waived)	$50 Copay	80%
Hospital Services – In-Patient	80%	80%	80%
In-Patient Physician Fees	80%	80%	80%
Emergency Room (copay waived if admitted)	$250 Copay	80%	80%
Urgent Care	$90 Copay (ded waived)	$35 Copay	80%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% (ded waived) 80% (ded waived)	 80% 80%	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$70 Copay (ded waived)	$35 Copay	80%
Ambulance Services (per trip)	$250 Copay	80%	80%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (ded waived) [3] $250 / $500 Ded - $55 Copay [3, 4] $250 / $500 Ded - $75 Copay [3, 4] $250 / $500 Ded - 80% (up to $250 per prescription [9]) [3, 4]	 $10 Copay (combined Med/Rx ded) [3] $20 Copay (combined Med/Rx ded) [3, 4] $40 Copay (combined Med/Rx ded) [3, 4] 80% (combined Med/Rx ded) [3, 4]	 80% (combined Med/Rx ded) [3] 80% (combined Med/Rx ded) [3, 4] 80% (combined Med/Rx ded) [3, 4] 80% (combined Med/Rx ded) [3, 4]
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$250 / $500 Ded – Applicable Rx Copay [3, 4]	Applicable Rx Copay (combined Med/Rx ded) [3, 4]	Applicable Rx Copay (combined Med/Rx ded) [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	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	80% (ded waived)	80%	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$45 Copay (ded waived)	$35 Copay	80%
Physical, Occupational, Speech Therapy	$45 Copay (ded waived)	$35 Copay	80%
Rehabilitative & Habilitative Services and Devices	$45 Copay (ded waived)	$35 Copay	80%
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	80%	80%

Services	HMO B	HMO C† HSA Qualified	HMO D† HSA Qualified
Participating Health Plans	Sutter Health Plus	Sutter Health Plus	Sutter Health Plus
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%	80%
Hospice	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80% (ded waived)	80%	80%
Mental Health In-Patient Out-Patient	 80% [11] $45 Copay (ded waived) [12]	 80% [11] $35 Copay [12]	 80% [11] 80% [12]
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 80%	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% (ded waived) [6] 1 pair per year [7] 1 pair per year None	 VSP Choice Network 100% (ded waived) [6] 1 pair per year [7] 1 pair per year None	 VSP Choice Network 100% (ded waived) [6] 1 pair per year [7] 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)	 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% (ded waived) $25 Copay Copay varies by service $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

† HSA Qualified High Deductible Plan
* All services are subject to the deductible unless otherwise stated.

1. 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.
2. Cost sharing amounts for all in-network services, including those applied to deductible, accumulate toward the out-of-pocket maximum.
3. 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.
4. Sexual dysfunction medications are subject to prior authorization, have a 50% cost share, and are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. Standard: 1 pair per year; Monthly: 6 pair per year; Bi-Weekly: 6 pair per year; Dailies: 1 month supply per year.
8. 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.
9. Maximum member responsibility.
10. If individual only coverage member will be subject to a lower deductible amount.
11. 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.
12. 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.

Silver HMO

Groups Beginning 4/1/16

Services	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [5] (applies to Max OOP)	$2,000 / $4,000 [5] (applies to Max OOP)	$2,000 / $4,000 [5] (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [6]	$6,500 / $13,000 [6]	$6,500 / $6,850 [6]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay (ded waived)	$45 Copay (ded waived)	75%
Specialist Visit (SPC)	$65 Copay (ded waived)	$65 Copay (ded waived)	75%
Laboratory	$25 Copay (ded waived)	$25 Copay (ded waived)	75%
X-Ray	$25 Copay (ded waived)	$25 Copay (ded waived)	75%
MRI, CT and PET	$200 Copay per procedure (ded waived)	$200 Copay per procedure (ded waived)	75%
Hospital Services – In-Patient	60%	60%	75%
In-Patient Physician Fees	60%	60%	75%
Emergency Room (copay waived if admitted)	$400 Copay (ded waived)	$400 Copay (ded waived)	75%
Urgent Care	$100 Copay (ded waived)	$100 Copay (ded waived)	75%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%	 75% 75%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$65 Copay (ded waived)	$65 Copay (ded waived)	75%
Ambulance Services (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	75%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (overall ded waived) $50 Copay (overall ded waived) [2] $100 Copay (overall ded waived) [2] 75% (up to $300 per prescription [4]) (overall ded waived) [2]	 $20 Copay (overall ded waived) $50 Copay (overall ded waived) [2] $100 Copay (overall ded waived) [2] 75% (up to $300 per prescription [4]) (overall ded waived) [2]	 $20 Copay (combined Med/Rx/ Pediatric dental ded) $50 Copay (combined Med/Rx/ Pediatric dental ded) [2] $100 Copay (combined Med/Rx/ Pediatric dental ded) [2] 75% (up to $300 per prescription [4]) (combined Med/Rx/Pediatric dental ded) [2]
Oral Contraceptives	100%	100%	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) [2]	Applicable Rx Copay (overall ded waived) [2]	Applicable Rx Copay (combined Med/ Rx/Pediatric dental ded) [2]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay (ded waived) [7]	$150 Copay (ded waived) [7]	75%
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay
Acupuncture	$10 Copay (ded waived)	$10 Copay (ded waived)	75%
Physical, Occupational, Speech Therapy	$45 Copay (ded waived)	$45 Copay (ded waived)	75%
Rehabilitative & Habilitative Services and Devices	$45 Copay (ded waived)	$45 Copay (ded waived)	75%

Services	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	$45 Copay (ded waived)	75%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	75%
Hospice	100% (ded waived)	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	$50 Copay (ded waived)	$50 Copay (ded waived)	75%
Mental Health In-Patient Out-Patient	 60% $40 Copay (ded waived)	 60% $40 Copay (ded waived)	 75% 75%
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 60%	 75%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) [3] Not Covered	 50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) [3] Not Covered	 50% See Plan Specific EOC Not Covered 50% [3] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 75% 75% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO Combined Med/Rx/Pediatric dental ded Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

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

Silver HMO

Groups Beginning 4/1/16

Services	HMO D	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [11] (applies to Max OOP)	$1,750 / $3,500 [1, 14] (applies to Max OOP)	$1,500 / $3,000 [1, 14] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [12]	$6,350 / $12,700 [2]	$6,500 / $13,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$45 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Specialist Visit (SPC)	$65 Copay (ded waived)	$50 Copay (ded waived)	$70 Copay (ded waived)
Laboratory	$25 Copay (ded waived)	$50 Copay (ded waived)	$35 Copay (ded waived)
X-Ray	$25 Copay (ded waived)	$50 Copay (ded waived)	$65 Copay (ded waived)
MRI, CT and PET	$200 Copay per procedure (ded waived)	$275 Copay (ded waived)	$250 Copay (ded waived)
Hospital Services – In-Patient	60%	80% [1, 4]	80% [1, 4]
In-Patient Physician Fees	60%	100% (ded waived)	80% [1, 4]
Emergency Room (copay waived if admitted)	$400 Copay (ded waived)	$250 Copay	$250 Copay [1]
Urgent Care	$100 Copay (ded waived)	$100 Copay	$90 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 80% [1, 4] 80% [1, 4]	 80% [1, 4] 80% [1, 4]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$65 Copay (ded waived)	$50 Copay (ded waived)	$70 Copay (ded waived)
Ambulance Services (per trip)	$100 Copay (ded waived)	100% (ded waived)	$250 Copay [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (overall ded waived) $50 Copay (overall ded waived) [9] $100 Copay (overall ded waived) [9] 75% (up to $300 per prescription [8]) (overall ded waived) [9]	 $25 Copay (ded waived) $250 / $500 Ded - $50 Copay [1] $250 / $500 Ded - $75 Copay [1] $250 / $500 Ded – 80% (up to $250 per 30 day supply [8]) [1, 4]	 $15 Copay (ded waived) $250 / $500 Ded - $55 Copay [1] $250 / $500 Ded - $75 Copay [1] $250 / $500 Ded - 80% (up to $250 per 30 day supply [8]) [1, 4]
Oral Contraceptives	100%	100%	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived) [9]	$250 / $500 Ded - $50 Copay [1]	$250 / $500 Ded - $55 Copay [1]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [6]	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay (ded waived) [13]	80% [1, 4]	80% [1, 4]
Chiropractic (20 visits max per year)	$15 Copay (ded waived)	Not Covered	$15 Copay (ded waived)
Acupuncture	$10 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Physical, Occupational, Speech Therapy	$45 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$45 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$45 Copay (ded waived)	100% (ded waived)	$45 Copay (ded waived)

Services	HMO D	HMO A	HMO B
Participating Health Plans	UnitedHealthcare	Western Health Advantage	Western Health Advantage
Network Name	Focus	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	80% [1, 4]	80% [1, 4]
Hospice	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	$50 Copay (ded waived)	80% (ded waived) [1, 4, 5]	80% [1, 4, 5]
Mental Health In-Patient Out-Patient	 60% $40 Copay (ded waived)	 80% [1, 4] $50 Copay (ded waived)	 80% [1, 4] $45 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 80% [1, 4]	 80% [1, 4]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) [10] Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% (ded waived) 60% (ded waived) 1 per calendar year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [7]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [7]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 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% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. Limited to one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.
8. Maximum member responsibility.
9. For Specialty drugs, please see plan specific EOC.
10. Benefits are limited to three (3) cycles or one (1) live birth per lifetime.
11. 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.
12. 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.
13. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
14. 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.

Silver HMO

Groups Beginning 4/1/16

Services	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Silver**
Calendar Year Deductible*	$2,600 / $4,000 [1, 9, 10] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,250 / $12,500 [2]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	80% [1, 4]
Specialist Visit (SPC)	80% [1, 4]
Laboratory	80% [1, 4]
X-Ray	80% [1, 4]
MRI, CT and PET	80% [1, 4]
Hospital Services – In-Patient	80% [1, 4]
In-Patient Physician Fees	80% [1, 4]
Emergency Room (copay waived if admitted)	80% [1, 4]
Urgent Care	80% [1, 4]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% [1, 4] 80% [1, 4]
Hospital Pre-Authorization	Required
2nd Surgical Opinion	80% [1, 4]
Ambulance Services (per trip)	80% [1, 4]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 80% [1, 4] (combined Med/Rx ded) 80% [1, 4] (combined Med/Rx ded) 80% [1, 4] (combined Med/Rx ded) 80% [1, 4] (combined Med/Rx ded)
Oral Contraceptives	100% (ded waived)
Diabetes – Self-Injectable	80% [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	80% [1, 4]
Chiropractic (20 visits max per year)	Not Covered
Acupuncture	80% [1, 4]
Physical, Occupational, Speech Therapy	80% [1, 4]
Rehabilitative & Habilitative Services and Devices	80% [1, 4]
Home Health Care (Max 100 visits per year)	80% [1, 4]

Services	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage
Network Name	Full
Metal Tier	**Silver**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80% [1, 4]
Hospice	100% [1]
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	80% [1, 4, 5]
Mental Health	
In-Patient	80% [1, 4]
Out-Patient	80% [1, 4]
Drug/Substance Abuse	
In-Patient (Detox Only)	80% [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 [7]
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 deducible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. Limited to one pair of standard hard or six pairs of standard soft contact lenses instead of glasses.
8. Maximum member responsibility.
9. If individual only coverage, member will be subject to the lowest deductible amount.
10. 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.

Silver 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	**Silver**		**Silver**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible*	$1,250 / $2,500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,500 / $5,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,500 / $3,000 (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,000 / $6,000 (combined Med/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,500 / $11,000 [1]	$11,000 / $22,000 [1]	$5,500 / $11,000 [1]	$11,000 / $22,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$25 Copay (first 3 visits) [9,10] – 60%	50%	$35 Copay (first 3 visits) [9,10] – 70%	50%
Specialist Visit (SPC)	$25 Copay (first 3 visits) [9,10] – 60%	50%	$35 Copay (first 3 visits) [9,10] – 70%	50%
Laboratory	60%	50%	70%	50%
X-Ray	60%	50%	70%	50%
MRI, CT and PET	60%	50% (up to $800 per test) [5]	70%	50% (up to $800 per test) [5]
Hospital Services – In-Patient	Tier 1: 60% Tier 2: $500 Copay – 60%	50% (up to $650 per day) [5]	$500 Copay	50% (up to $650 per day) [5]
In-Patient Physician Fees	60%	50%	70%	50%
Emergency Room (copay waived if admitted)	60%		$300 Copay	
Urgent Care	60%	50%	70%	50%
Hospital Services – Out-Patient				
Surgical Facility	Tier 1: 60% Tier 2: $250 Copay – 60%	50% (up to $380 per admit) [5]	$300 Copay	50% (up to $380 per admit) [5]
Ambulatory Surgery Center	Tier 1: 60% Tier 2: $250 Copay – 60%	50% (up to $380 per admit) [5]	$300 Copay	50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Required		Required	
2nd Surgical Opinion	$25 Copay (first 3 visits) [9,10] – 60%	50%	$35 Copay (first 3 visits) [9,10] – 70%	50%
Ambulance Services (per trip)	60%		70%	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	$15 Copay (ded waived) [2] $250 / $500 Ded – $40 Copay [2] $250 / $500 Ded – $80 Copay [2] $250 / $500 Ded – 70% (up to $250 per prescription [8]) [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 $250 per prescription [8]) [2,6]	
Oral Contraceptives	100%		100%	
Diabetes – Self-Injectable	$250 / $500 Ded – 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	60%	50%	70%	50%
Chiropractic (20 visits max per year)	$25 Copay (first 3 visits) [9,10] – 60%	50% (up to $25 per visit) [5]	$35 Copay (first 3 visits) [9,10] – 70%	50% (up to $25 per visit) [5]
Acupuncture	$25 Copay (first 3 visits) [9,10] – 60%	50%	$35 Copay (first 3 visits) [9,10] – 70%	50%
Physical, Occupational, Speech Therapy	$25 Copay (first 3 visits) [9,10] – 60%	50%	$35 Copay (first 3 visits) [9,10] – 70%	50%
Rehabilitative & Habilitative Services and Devices	$25 Copay (first 3 visits) [9,10] – 60%	50%	$35 Copay (first 3 visits) [9,10] – 70%	50%
Home Health Care (Max 100 visits per year)	60% [4]	50% (up to $75 per visit) [4,5]	70% [4]	50% (up to $75 per visit) [4,5]

Services	PPO A		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	Tier 1: 60% Tier 2: $500 Copay – 60% (100 days max per year)	50% (up to $150 per day)[5] (100 days max per year)	$500 Copay (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)	60%	50%	70%	50%
Mental Health In-Patient Out-Patient	 Tier 1: 60% Tier 2: $500 Copay – 60% $25 Copay (first 3 visits)[9,10] – 60%	 50% (up to $650 per day)[5] 50%	 $500 Copay $35 Copay (first 3 visits)[9,10] – 70%	 50% (up to $650 per day)[5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 Tier 1: 60% Tier 2: $500 Copay – 60%	 50% (up to $650 per day)[5]	 $500 Copay	 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] – 60%[7] Not Covered Not Covered Not Covered Not Covered	 50%[7] Not Covered Not Covered Not Covered Not Covered	 $35 Copay (first 3 visits)[9,10] – 70%[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.

Silver EPO

Groups Beginning 4/1/16

Services	EPO A
Participating Health Plans	Anthem Blue Cross
Network Name	Prudent Buyer - Small Group
Metal Tier	**Silver**
Calendar Year Deductible*	$2,000 / $4,000 [2] (combined Med/ Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000 [3]
Lifetime Maximum	Unlimited
Dr. Office Visits (PCP)	$50 Copay (first 3 visits) [8, 9] – 70%
Specialist Visit (SPC)	$50 Copay (first 3 visits) [8, 9] – 70%
Laboratory	70%
X-Ray	70%
MRI, CT and PET	70%
Hospital Services – In-Patient	$750 Copay
In-Patient Physician Fees	70%
Emergency Room (copay waived if admitted)	$300 Copay
Urgent Care	70%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $300 Copay $300 Copay
Hospital Pre-Authorization	Required
2nd Surgical Opinion	$50 Copay (first 3 visits) [8] – 70%
Ambulance Services (per trip)	70%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $15 Copay (overall ded waived) $40 Copay (overall ded waived) $80 Copay (overall ded waived) 70% (up to $500 per prescription [7]) (overall ded waived) [5]
Oral Contraceptives	100%
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived)
Pre-Existing Conditions	Covered
Maternity and Newborn Care	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness
Chemotherapy	70%
Chiropractic (20 visits max per year)	$50 Copay (first 3 visits) [8, 9] – 70%
Acupuncture	$50 Copay (first 3 visits) [8, 9] – 70%
Physical, Occupational, Speech Therapy	$50 Copay (first 3 visits) [8, 9] – 70%

Services	EPO A
Participating Health Plans	Anthem Blue Cross
Network Name	Prudent Buyer - Small Group
Metal Tier	**Silver**
Rehabilitative & Habilitative Services and Devices	$50 Copay (first 3 visits)[8, 9] – 70%
Home Health Care (Max 100 visits per year)	70%[4]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$750 Copay (100 days max per year)
Hospice	100%
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	70%
Mental Health In-Patient Out-Patient	 $750 Copay $50 Copay (first 3 visits)[8, 9] – 70%
Drug/Substance Abuse In-Patient (Detox Only)	 $750 Copay
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $50 Copay (first 3 visits)[8, 9] – 70%[6] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% (ded waived) 50% 50% 50%

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. 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.
3. 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.
4. Limited to 100 4-hour visits per year.
5. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
6. Evaluation only.
7. Maximum member responsibility.
8. 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.
9. Deductible is waived for the first three visits combined.

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 Ambulatory Surgery Center	 50% 50%	 50% 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 Formulary Brand Non-Formulary Brand Specialty	 $35 Copay (ded waived) [5] $250 Ded – $75 Copay [5] $250 Ded – $150 Copay [5] $250 Ded – 70% (up to $500 per prescription [12]) [5, 11]	 $35 Copay (ded waived) [5] $250 Ded - $75 Copay [5] $250 Ded - $150 Copay [5] $250 Ded – 70% (up to $500 per prescription [12]) [5, 11]	 $15 Copay (ded waived) $45 Copay (combined Med/Rx ded) 50% (combined Med/Rx ded) 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

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 Out-Patient	 50% $50 Copay (ded waived)	 50% $50 Copay (ded waived)	 50% $45 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 50%	 50%	 50%
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 [10] Not Covered	 See Plan Specific EOC See Plan Specific EOC Not Covered Covered [10] Not Covered	 50% [3] 50% [3] Not Covered 50% [3] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed EyeMed $50 Copay (ded waived) 100% (Pref. Provider) 100% (Pref. Provider) 1 per calendar year	 EyeMed EyeMed $50 Copay (ded waived) 100% (Pref. Provider) 100% (Pref. Provider) 1 per calendar year	 EyeMed [4] EyeMed 100% 100% 1 pair per calendar year 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)	 Aetna PPO Combined Med/Pediatric dental ded $1,000 / $2,000 100% 100% (ded waived) 70% 50% 50%	 Aetna PPO Combined Med/Pediatric dental ded $1,000 / $2,000 100% 100% (ded waived) 70% 50% 50%	 Dental Benefit Providers [4, 7] Dental Benefit Providers None None 100% 100% $25 Copay $300 Copay $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.

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 Ambulatory Surgery Center	 60% 60%	 75% 75%	 60% 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 Formulary Brand Non-Formulary Brand Specialty	 $1,000 Ded – $20 Copay $1,000 Ded –$50 Copay $1,000 Ded –$50 Copay (with physician approval) $1,000 Ded – 80% (up to $250 per prescription [9]) (with physician approval)	 75% (combined Med/Rx ded) 75% (combined Med/Rx ded) 75% (combined Med/Rx ded) (with physician approval) 75% (up to $250 per prescription [9]) (combined Med/Rx ded) (with physician approval)	 $19 Copay (ded waived) $60 Copay (combined Med/Rx ded) $120 Copay (combined Med/Rx ded) 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	60%	75%	$1,500 Copay per day – 3 days max
Out-Patient	$60 Copay [12]	75%	$120 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	75%	$1,500 Copay per day – 3 days max
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Kaiser Permanente	Kaiser Permanente	VSP
Network	Kaiser Permanente	Kaiser Permanente	VSP
Exam	100% (ded waived)	100% (ded waived)	100%
Contact Lenses	1 pair per calendar year	1 pair per calendar year	1 pair in lieu of eyeglasses
Frames	1 pair per calendar year (ded waived)	1 pair per calendar year (ded waived)	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Premier Access
Network	DeltaCare USA	DeltaCare USA	Access Dental DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 /$700	$1,000 / $2,000 [7]
Office Visit	100% (ded waived)	100% (ded waived)	$20 Copay
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100%
Basic Services	$95 Copay [2]	$95 Copay [2]	$95 Copay [2]
Major Services (no waiting period)	$365 Copay [3]	$365 Copay [3]	$365 Copay [3]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. 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 information on preventive services.
6. 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.
7. 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.
8. Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
9. Maximum member responsibility.
10. 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.
11. 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.
12. 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 Ambulatory Surgery Center	 60% 60%	 60% 60%	 100% [19] 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 Formulary Brand Non-Formulary Brand Specialty	 60% (combined Med/Rx ded) 60% (combined Med/Rx ded) 60% (combined Med/Rx ded) 60% (combined Med/Rx ded)	 60% (combined Med/Rx ded) 60% (combined Med/Rx ded) 60% (combined Med/Rx ded) 60% (combined Med/Rx ded)	 $500/$1,000 Ded – 100% [19] (up to $500 per prescription [16]) [3] $500/$1,000 Ded – 100% [19] (up to $500 per prescription [16]) [3, 4] $500/$1,000 Ded – 100% [19] (up to $500 per prescription [16]) [3, 4] $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 Out-Patient	 60% 60%	 60% 60%	 100% [17, 19] $70 Copay [18]
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 60%	 100% [19]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP VSP 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [7] 1 pair per year [8] 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 [14] $20 Copay 100% $95 Copay [12] $365 Copay [13] $1,000 Copay	 Premier Access Access Dental DHMO None $1,000 / $2,000 [14] $20 Copay 100% $95 Copay [12] $365 Copay [13] $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

† HSA Qualified High Deductible Plan

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

1. 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.
2. Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum.
3. 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.
4. Sexual dysfunction medications are subject to prior authorization, have a 50% cost share, and are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. 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 34)

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 Ambulatory Surgery Center	 60% 60%	 100% 100%	 60% 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 Formulary Brand Non-Formulary Brand Specialty	 60% (combined Med/Rx ded)[10] 60% (combined Med/Rx ded)[10, 11] 60% (combined Med/Rx ded)[10, 11] 60% (combined Med/Rx ded)[10, 11]	 $25 Copay (ded waived) $250 / $500 Ded – $50 Copay[6] $250 / $500 Ded – $125 Copay[6] $250 / $500 Ded – 50% (up to $300 per prescription[9])[6]	 $20 Copay (combined Med/Rx/Pediatric dental ded) $50 Copay (combined Med/Rx/Pediatric dental ded)[6] $100 Copay (combined Med/Rx/Pediatric dental ded)[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 Out-Patient	 60% 60%	 100% $40 Copay (ded waived)	 60% 60%
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 100%	 60%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 50% (ded waived) See Plan Specific EOC Not Covered 50% (ded waived) [8] Not Covered	 50% See Plan Specific EOC Not Covered 50% [8] Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 VSP Choice Network 100% (ded waived) [12] 1 pair per year [13] 1 pair per year None	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year	 UnitedHealthcare Vision Spectera Eyecare Networks 100% (ded waived) 60% 60% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) $25 copay Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 UnitedHealthcare Dental CA DHMO Combined Med/Rx/Pediatric dental ded Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.
3. 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 34)

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 Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]	 100% [1, 11] 100% [1, 11]	 100% [1] 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 Formulary Brand Non-Formulary Brand Specialty	 60% [1, 4] 60% [1, 4] 60% [1, 4] 60% [1, 4]	 $500 /$1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1] $500 /$1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1] $500 /$1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1] $500 /$1,000 Ded – 100% [11] (up to $500 per prescription [8]) [1]	 100% [1] (combined Med/Rx ded) 100% [1] (combined Med/Rx ded) 100% [1] (combined Med/Rx ded) 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 [8]) [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 Out-Patient	 60% [1, 4] 60% [1, 4]	 100% [1, 11] $70 Copay [9]	 100% [1] 100% [1]
Drug/Substance Abuse In-Patient (Detox Only)	 60% [1, 4]	 100% [1, 11]	 100% [1]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% 100% (ded waived) 1 per calendar year [10]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [10]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [10]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Full None Combined with Medical 100% 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 Access Dental Full None Combined with Medical 100% 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay	 Access Dental Full None Combined with Medical 100% 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. 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 Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]
Hospital Pre-Authorization	Required
2nd Surgical Opinion	60% [1, 4]
Ambulance Services (per trip)	60% [1, 4]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% [1, 4] (combined Med/Rx ded) 60% [1, 4] (combined Med/Rx ded) 60% [1, 4] (combined Med/Rx ded) 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 Out-Patient	 60% [1, 4] 60% [1, 4]
Drug/Substance Abuse In-Patient (Detox Only)	 60% [1, 4]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [8]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Access Dental Full None Combined with Medical 100% 100% (ded waived) Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deducible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount that the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. 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 Ambulatory Surgery Center	 $500 Copay $500 Copay	 80% 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 Formulary Brand Non-Formulary Brand Specialty	 $19 Copay (ded waived) $750 / $1,500 Ded – $50 Copay $750 / $1,500 Ded – $90 Copay $750 / $1,500 Ded – 70% (up to $500 per prescription [3]) [4]	 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%	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 Out-Patient	 $1,000 Copay $65 Copay (first 3 visits) [8,9] – 60%	 80% 80%
Drug/Substance Abuse In-Patient (Detox Only)	 $1,000 Copay	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 $65 Copay (first 3 visits) [8,9] – 60% [7] Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 1 pair per calendar year 1 pair per calendar year (ded waived) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Pediatric dental ded Combined with Medical 100% 100% (ded waived) 50% 50% 50%	 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. Maximum member responsibility.
4. Classified specialty drugs must obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
5. Limited to 100 4-hour visits per year.
6. See plan specific EOC for information on preventive services.
7. Evaluation only.
8. 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.
9. Deductible is waived for the first three visits combined.

(Foot notes continued from page 25)

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 27)

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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