Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 7/1/21

Bronze

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

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

Bronze HMO

Groups Beginning 7/1/21

Services	HMO A	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	CommunityCare	Full	Full
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 (applies to Max OOP)	$6,300 / $12,600[17] (applies to Max OOP)	$5,400 / $10,800[17] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,200 / $16,400	$8,200 / $16,400[2]	$8,200 / $16,400[2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay[9]	$65 Copay[9]	$60 Copay[9]
Specialist Visit (SPC)	$95 Copay[9]	$95 Copay[9]	$80 Copay[9]
Laboratory	$40 Copay (ded waived)	$40 Copay (ded waived)	$30 Copay
X-Ray	60%	60%	50%
MRI, CT and PET (office setting)	60%	60% per procedure	50% per procedure
Virtual/Telemedicine Office Visit	100% (ded waived)	100% (ded waived)	100% (ded waived)
Hospital Services – In-Patient	60%	60%	50%
In-Patient Physician Fees	60%	60%	50%
Emergency Room (copay waived if admitted)	60%	60%	50%
Urgent Care	$65 Copay[9]	$65 Copay[9]	$60 Copay[9]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%[11]	 60% 60%	 50% 50%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$95 Copay[9]	$95 Copay[9]	$80 Copay[9]
Ambulance Services (per trip)	60%	60%	50%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – $18 Copay[13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription[6])[13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription[6])[13, 14] $500 / $1,000 Ded – 60% (up to $500 per prescription[6])(prior auth. required)[13, 14]	 $500 / $1,000 Ded – $18 Copay $500 / $1,000 Ded – 60% (up to $500 per prescription[6]) $500 / $1,000 Ded – 60% (up to $500 per prescription[6]) (with physician approval) $500 / $1,000 Ded – 60% (up to $500 per prescription[6])(with physician approval)	 $20 Copay (ded waived) 50% (up to $500 per prescription[6]) (combined Med/Rx ded) 50% (up to $500 per prescription[6]) (combined Med/Rx ded) (with physician approval) 50% (up to $500 per prescription[6]) (combined Med/Rx ded)(with physician approval)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – Applicable Rx Copay	$500 / $1,000 Ded – 60% (up to $500 per prescription[6])	50% (up to $500 per prescription[6]) (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)[4]	100% (ded waived)[4]	100% (ded waived)[4]
Chronic Disease Management	$95 Copay[9]	Covered as any illness	Covered as any Illness
Chemotherapy	60%	60%	50%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	$15 Copay (ded waived)[18]
Acupuncture	$65 Copay[9, 16]	$65 Copay	$60 Copay[18]
Physical, Occupational, Speech Therapy	$65 Copay (ded waived)[1]	$65 Copay (ded waived)	$65 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived)[1]	$65 Copay (ded waived)	$65 Copay (ded waived)

Services	HMO A	HMO A	HMO B
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	CommunityCare	Full	Full
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	60% [10]	50% [10]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% (no limit)	60%	50%
Hospice (out-patient)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60%	60% [19]	50% [19]
Mental Health In-Patient Out-Patient (office visit)	 60% [15] $65 Copay (ded waived) [15]	 60% $65 Copay [9]	 50% $60 Copay [9]
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 60%	 50%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 EyeMed [3] EyeMed 100% (ded waived) 100% (ded waived) 1 pair per calendar year (ded waived) None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [12] 1 pair per calendar year (ded waived) [12] None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [12] 1 pair per calendar year (ded waived) [12] None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Dental Benefit Providers [3, 5] Dental Benefit Providers None Combined with Medical 100% (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [7] $365 Copay [8] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [7] $365 Copay [8] $350 Copay

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

1. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
2. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
3. Pediatric dental and vision are included on all plans.
4. See plan specific EOC for information on preventive services.
5. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
6. Maximum member responsibility.
7. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
8. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
9. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).
10. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
11. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
12. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
13. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
14. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
15. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
16. Must be medically necessary.
17. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
18. 20 visits max per year combined for Chiropractic and Acupuncture.
19. 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.

Bronze HMO

Groups Beginning 7/1/21

Services	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$7,000 / $14,000 [12] (combined Med/Rx ded)(applies to Max OOP)	$7,600 / $15,200 [4] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000 [13]	$7,900 / $15,800 [4, 11]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	$55 Copay
Specialist Visit (SPC)	100%	$55 Copay
Laboratory	100%	$15 Copay
X-Ray	100%	$55 Copay
MRI, CT and PET (office setting)	100% per procedure	$175 Copay per procedure
Virtual/Telemedicine Office Visit	100%	Covered as any Illness
Hospital Services – In-Patient	100%	$1,500 Copay per day – 3 days max
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	100%	$500 Copay
Urgent Care	100%	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% 100%	 60% 60%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	100%	$55 Copay
Ambulance Services (per trip)	100%	$500 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) (with physician approval) 100% (combined Med/Rx ded) (with physician approval)	 $19 Copay (ded waived) $60 Copay (combined Med/Rx ded) $100 Copay (combined Med/Rx ded) Applicable Rx Copay (combined Med/Rx ded)
Oral Contraceptives	100% (ded waived)	100% (if in formulary)
Diabetes – Self-Injectable	100% (combined Med/Rx ded)	Applicable Rx Copay (combined Med/Rx ded)
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	$800 Copay per day – 3 days max [9]
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	Covered as any Illness	$55 Copay
Chemotherapy	100%	Variable [8]
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	100%	$55 Copay
Physical, Occupational, Speech Therapy	100%	$55 Copay
Rehabilitative & Habilitative Services and Devices	100%	$55 Copay

Services	HMO C† HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Sharp
Network Name	Full	Premier
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	100% [1]	$55 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%	$25 Copay per day
Hospice (out-patient)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	100% [6]	50%
Mental Health In-Patient Out-Patient (office visit)	 100% 100%	 $125 Copay per day – 3 days max $55 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 100%	 $125 Copay per day – 3 days max
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [10] 1 pair per calendar year (ded waived) [10] None	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $95 Copay [2] $365 Copay [3] $350 Copay	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [7] 100% [14] $25 Copay [15] $300 Copay [16] $1,000 Copay [17]

† HSA Qualified High Deductible Plan

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

1. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximum per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
2. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
3. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
4. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.
5. See plan specific EOC information on preventive services.
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. Refers to procedure code D0999
8. Copayment/Coinsurance waived if seen by a nurse or in an out-patient setting.
9. Amount listed for In-Patient Services only.
10. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
11. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
12. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
13. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
14. Refers to procedure codes D0120 and D1120/D1110
15. Refers to procedure code D2140
16. Refers to procedure code D3330
17. Refers to procedure code D8080/D8090

Bronze HMO

Groups Beginning 7/1/21

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,200 / $12,400 [10] (combined Med/Rx ded)(applies to Max OOP)	$6,300 / $12,600 [1] (applies to Max OOP)	$7,000 / $14,000 [1] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,900 / $13,800 [10, 17]	$8,200 / $16,400 [2]	$7,000 / $14,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$65 Copay [8, 9]	100% [9]
Specialist Visit (SPC)	60%	$95 Copay [8]	100%
Laboratory	60%	$40 Copay (ded waived)	100%
X-Ray	60%	60%	100%
MRI, CT and PET (office setting)	60%	60%	100%
Virtual/Telemedicine Office Visit	Covered as any Illness	Vraiable [20]	Variable [20]
Hospital Services – In-Patient	60%	60%	100%
In-Patient Physician Fees	60%	60%	100%
Emergency Room (copay waived if admitted)	60%	60%	100%
Urgent Care	60%	$65 Copay [8]	100%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	$95 Copay [8]	100%
Ambulance Services (per trip)	60%	60%	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) Applicable Rx Copay (combined Med/Rx ded)	 $500 / $1,000 Ded – $18 Copay [3, 4] $500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4] $500 / $1,000 Ded – 60% (up to $500 per prescription [15]) [3, 4]	 100% (combined Med/Rx ded) [3, 4] 100% (combined Med/Rx ded) [3, 4] 100% (combined Med/Rx ded) [3, 4] 100% (combined Med/Rx ded) [3, 4]
Oral Contraceptives	100% (if in formulary)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (combined Med/Rx ded)	$500 / $1,000 Ded – Applicable Rx Copay [3, 4]	Applicable Rx Copay (combined Med/Rx ded) [3, 4]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	60% [18]	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%	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [11]	60%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	60%	$65 Copay [8]	100%
Physical, Occupational, Speech Therapy	60%	$65 Copay (ded waived)	100%
Rehabilitative & Habilitative Services and Devices	60%	$65 Copay (ded waived)	100%

Services	HMO B† HSA Qualified	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60%	60%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	100%
Hospice (out-patient)	100%	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	50%	60%	100%
Mental Health In-Patient Out-Patient (office visit)	 60% 60%	 60% [16] $65 Copay [8]	 100% [16] 100%
Drug/Substance Abuse In-Patient (Detox Only)	 60%	 60% [16]	 100% [16]
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 Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None	 VSP Choice Network 100% (ded waived) [6] 100% (in lieu of eyeglasses) (ded waived) [6, 7] 100% (in lieu of contact lenses) (ded waived) [6, 7] 1 pair per year	 VSP Choice Network 100% (ded waived) [6] 100%(in lieu of eyeglasses) (ded waived) [6, 7] 100% (in lieu of contact lenses) (ded waived) [6, 7] 1 pair per year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [14] 100% [18] $25 Copay [12] $300 Copay [13] $1,000 Copay [19]	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service (ded waived) 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)	 Delta Dental DeltaCare USA None Combined with Medical Copay varies by service 100% (ded waived) Copay varies by service (ded waived) Copay varies by service (ded waived) $1,000 Copay (ded waived)

† HSA Qualified High Deductible Plan

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

1. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high-deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $2,800 for 2021 plans.
2. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
3. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost. Member cost sharing for oral anti-cancer drugs shall not exceed $250 per prescription for up to a 30-day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.
4. Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every 12 months.
8. When outpatient benefits have Cost Sharing that includes "deductible waived for 1st 3 non-preventive visits", the Deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient MH/SUD visits.

(Footnotes continued on page 16)

Bronze HMO

Groups Beginning 7/1/21

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 [1, 7] (applies to Max OOP)	$7,000 / $14,000 [1, 7] (combined Med/Rx ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,200 / $16,400 [2, 7]	$7,000 / $14,000 [2, 7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay [9]	100% [1]
Specialist Visit (SPC)	$95 Copay [9]	100% [1]
Laboratory	$40 Copay (ded waived)	100% [1]
X-Ray	60% [1, 4]	100% [1]
MRI, CT and PET (office setting)	60% [1, 4]	100% [1]
Virtual/Telemedicine Office Visit	Variable [13]	Variable [13]
Hospital Services – In-Patient	60% [1, 4]	100% [1]
In-Patient Physician Fees	60% [1, 4]	100% [1]
Emergency Room (copay waived if admitted)	60% [1, 4]	100% [1]
Urgent Care	$65 Copay [1]	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$95 Copay [9]	100% [1]
Ambulance Services (per trip)	60% [1, 4]	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $500 / $1,000 Ded – $18 Copay [1] $500 / $1,000 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4, 11] $500 / $1,000 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4, 11] $500 / $1,000 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4]	 100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$500 / $1,000 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4]	100% (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	60% [1, 4]	100% [1]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) [12]	100% [1, 12]
Acupuncture	$15 Copay [1]	100% [1]
Physical, Occupational, Speech Therapy	$65 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$65 Copay (ded waived)	100% [1]

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	60% [1, 4]	100% [1]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% [1, 4]	100% [1]
Hospice (out-patient)	100% (ded waived)	100% [1]
Durable Medical Equipment (Covered when medically necessary)	60% [1, 4, 5]	100% [1]
Mental Health In-Patient Out-Patient (office visit)	 60% [1, 4] $65 Copay [9]	 100% [1] 100% [1]
Drug/Substance Abuse In-Patient (Detox Only)	 60% [1, 11]	 100% [1]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [10]	 MES Vision Eyewear Only 100% (ded waived) 100% (ded waived) 100% (ded waived) 1 per calendar year [10]
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay	 Delta Dental DeltaCare USA None Combined with Medical 100% 100% Copay varies by service Copay varies by service $1,000 Copay

† HSA Qualified High Deductible Plan

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

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

Bronze PPO

Groups Beginning 7/1/21

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$5,800 / $11,600 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$11,600 / $23,200 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$5,800 / $11,600 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$11,600 / $23,200 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000 [1]	$14,000 / $28,000 [1]	$7,000 / $14,000 [1]	$14,000 / $28,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	65%	50%	65%	50%
Specialist Visit (SPC)	65%	50%	65%	50%
Laboratory	65%	50%	65%	50%
X-Ray	65%	50%	65%	50%
MRI, CT and PET (office setting)	65%	50% (up to $800 per test) [5]	65%	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	Variable [15]	50%	Variable [15]	50%
Hospital Services –In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%		65%	
Urgent Care	65%	50%	65%	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay per admit - 65% 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $200 Copay per admit - 65% 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	65%	50%	65%	50%
Ambulance Services (per trip)	65% [13]		65% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 65% / Level 2 55% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2] Level 1 65% / Level 2 55% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2] Level 1 65% / Level 2 55% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2] Level 1 65% / Level 2 55% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 Level 1 65% / Level 2 55%(up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2] Level 1 65% / Level 2 55% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2] Level 1 65% / Level 2 55% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2] Level 1 65% / Level 2 55% (up to $500 per prescription [8]) (combined Med/Rx/Pediatric dental ded) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered as any Illness		Covered as any Illness	
Chemotherapy	65%	50% [14]	65%	50% [14]

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered	50% (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	65%	Not Covered	65%	Not Covered
Physical, Occupational, Speech Therapy	65%	50% [14]	65%	50% [14]
Rehabilitative & Habilitative Services and Devices	65% [11]	50% [11]	65% [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [12]	50% (up to $150 per day) [5, 12]	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health In-Patient Out-Patient (office visit)	 65% 65%	 50% (up to $650 per day) [5] 50%	 65% 65%	 50% (up to $650 per day) [5] 50%
Drug/Substance Abuse In-Patient (Detox Only)	 65%	 50% (up to $650 per day) [5]	 65%	 50% (up to $650 per day) [5]
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 65% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered	 65% [7] Not Covered Not Covered Not Covered Not Covered	 50% [7] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision Blue View Vision 100% (ded waived) 100% (in lieu of eyeglasses) 100% (ded waived) (1 per calendar year) 1 per calendar year	 Anthem Vision $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) $0 Copay plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses) $0 Copay plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year) 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Prime Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%	 Anthem Dental Combined Med/Rx/Pediatric dental ded (IN & OON) Combined with Medical (IN & OON) 100% 100% 50% 50% 50%

(Footnotes continued on page 16)

Bronze EPO

Groups Beginning 7/1/21

Services	EPO A	EPO A† HSA Qualified	EPO B† HSA Qualified
Participating Health Plans	Anthem Blue Cross	Cigna + Oscar	Cigna + Oscar
Network Name	Prudent Buyer – Small Group	LocalPlus	LocalPlus
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,600 / $11,200 [1] (combined Med/Pediatric dental ded) (applies to Max OOP)	$5,500 / $11,000 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$6,500 / $13,000 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,500 / $17,000 [2]	$7,000 / $14,000	$7,000 / $14,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$65 Copay	60%	60%
Specialist Visit (SPC)	$85 Copay	60%	60%
Laboratory	60%	60%	60%
X-Ray	60%	60%	60%
MRI, CT and PET (office setting)	60% [14]	60%	60%
Virtual/Telemedicine Office Visit	Variable [8]	100% (ded waived)	100% (ded waived)
Hospital Services – In-Patient	60%	60%	60%
In-Patient Physician Fees	60%	60%	60%
Emergency Room (copay waived if admitted)	$250 Copay – 60%	$650 Copay	60%
Urgent Care	60%	60%	60%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay per admit - 60% 60%	 $500 Copay $500 Copay	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$85 Copay	60%	60%
Ambulance Services (per trip)	60% [10]	$650 Copay	60%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $20 / Level 2 $25 Copay (ded waived) [9] $625 / $1,250 Ded - Level 1 $65 Copay / Level 2 $100 Copay [9] $625 / $1,250 Ded - Level 1 $105 Copay / Level 2 $140 Copay [9] $625 / $1,250 Ded - Level 1 70% / Level 2 60% (up to $500 per prescription [3]) (prior auth. required) [4, 9]	 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded) 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded) 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded) 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded)	 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded) 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded) 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded) 60% (up to $250 per prescription [3]) (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100%	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [9]	Applicable Ded / Rx Copay	Applicable Ded / Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [6]	100% (ded waived) [6]	100% (ded waived) [6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	60%	60%	60%
Chiropractic (20 visits max per year)	50% (ded waived) (20 visits max per benefit period) [11]	60%	60%
Acupuncture	$65 Copay	60%	60%
Physical, Occupational, Speech Therapy	60%	60%	60%

Services	EPO A	EPO A† HSA Qualified	EPO B† HSA Qualified
Participating Health Plans	Anthem Blue Cross	Cigna + Oscar	Cigna + Oscar
Network Name	Prudent Buyer – Small Group	LocalPlus	LocalPlus
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Rehabilitative & Habilitative Services and Devices	60% [12]	60%	60%
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [5]	60%	60%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60% [13]	60%	60%
Hospice (out-patient)	100%	60%	60%
Durable Medical Equipment (Covered when medically necessary)	50%	60%	60%
Mental Health			
In-Patient	60%	60%	60%
Out-Patient (office visit)	60%	60%	60%
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	60%	60%
Infertility			
Infertility Evaluation and Treatment	$65 Copay [7]	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	Anthem Vision	Davis Vision	Davis Vision
Network	Blue View Vision	Davis National Network	Davis National Network
Exam	100% (ded waived)	100%	100%
Contact Lenses	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)
Frames	100% (ded waived)	100%	100%
Maximum Allowance per year	1 per calendar year	1 per benefit period [15]	1 per benefit period [15]
Pediatric Dental			
Carrier	Anthem Dental	Liberty Dental	Liberty Dental
Network	Prime	CA Exchange	CA Exchange
Deductible	Combined Med/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded	Combined Med/Rx/Pediatric dental ded
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	80%	80%
Diagnostic & Preventative (D&P)	100%	100% (ded waived) [16]	100% (ded waived) [16]
Basic Services	50%	80%	80%
Major Services (no waiting period)	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%

† HSA Qualified High Deductible Plan

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

1. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
2. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family
3. Maximum member responsibility.
4. Classified specialty drugs must obtained through our Specialty Pharmacy Program and are subject to the terms of the program.
5. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period.
6. See plan specific EOC for information on preventive services.
7. Evaluation only.
8. Cost share amount varies based on type of services rendered and plan.
9. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
10. Medical emergency only.
11. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
12. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
13. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Maximum $150 allowance for Lenses and Frames, or Contact Lenses per benefit period.
16. One preventive visit per 6 months.

Bronze EPO

Groups Beginning 7/1/21

Services	EPO A† HSA Qualified	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$7,000 / $14,000 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$8,550 / $17,100 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$8,550 / $17,100 (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,000 / $14,000	$8,550 / $17,100	$8,550 / $17,100
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	100%	$75 Copay (first 2 visits)[9] – 100%
Specialist Visit (SPC)	100%	100%	100%
Laboratory	100%	100%	100%
X-Ray	100%[7]	100%[7]	100%[7]
MRI, CT and PET (office setting)	100%[7]	100%[7]	100%[7]
Virtual/Telemedicine Office Visit	100% (ded waived)	100% (ded waived)	100% (ded waived)
Hospital Services – In-Patient	100%	100%	100%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	100%	100%	100%
Urgent Care	100%	$75 Copay (ded waived)	$75 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% 100%	 100% 100%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	100%[6]	100%[6]	100%[6]
Ambulance Services (per trip)	100%	100%	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded / Rx Copay	Applicable Ded / Rx Copay	Applicable Ded / Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[1]	100% (ded waived)[1]	100% (ded waived)[1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	100%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	100%	100%	100%
Physical, Occupational, Speech Therapy	100%	100%	100%

Bronze EPO

Groups Beginning 7/1/21

Services	EPO A† HSA Qualified	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Rehabilitative & Habilitative Services and Devices	100% [4]	100% [4]	100% [4]
Home Health Care (Max 100 visits per year)	100% (Max 100 visits per benefit period)	100% (Max 100 visits per benefit period)	100% (Max 100 visits per benefit period)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%	100%	100%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	100% [8]	100% [8]	100% [8]
Mental Health In-Patient Out-Patient (office visit)	 100% 100%	 100% 100%	 100% $75 Copay (first 2 visits) [9] – 100%
Drug/Substance Abuse In-Patient (Detox Only)	 100%	 100%	 100%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Covered for Evaluation Only [5] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [5] Not Covered Not Covered Not Covered Not Covered	 Covered for Evaluation Only [5] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision 100% (ded waived) [2, 3] 100% (ded waived) (only in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year	 Oscar Davis Vision 100% (ded waived) [2, 3] 50% (ded waived) (only in lieu of eye-glasses) 50% (ded waived) 1 pair per calendar year	 Oscar Davis Vision 100% (ded waived) [2, 3] 50% (ded waived) (only in lieu of eyeglasses) 50% (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)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical 100% (ded waived) 100% (ded waived) [3] 80% (ded waived) 50% (ded waived) (prior auth. required) 50% (ded waived) (prior auth. required)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical 100% (ded waived) 100% (ded waived) [3] 100% 100% (prior auth. required) 100% (prior auth. required)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical 100% (ded waived) 100% (ded waived) [3] 100% 100% (prior auth.required) 100% (prior auth. required)

† HSA Qualified High Deductible Plan

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

1. See plan specific EOC for information on preventive services.
2. Limit one exam per 12 months.
3. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
4. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost share.
5. Basic infertility services (diagnosis) only for qualified members. See plan documents for additional details.
6. 2nd Surgical Opinion cost share is paired with the Out-Patient Specialist Visit.
7. Prior-Authorization may be required.
8. Prior-Authorization required if annual cost is greater than $500.
9. Deductible waived for first two non-preventive care visits (PCP, Mental Health and Substance Abuse combined).

Additional Footnotes

Groups Beginning 7/1/21

Bronze HMO

(Footnotes continued from page 7)

9. Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk-in Care visits.
10. In a high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum work differently. In a Self-Only coverage plan, you must meet the Self-Only Deductible and the Self -Only Out-of-Pocket Maximum. Once you meet the Self-Only Deductible, Sharp Health Plan will pay for your services. The Self-Only Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In a Family plan, each individual in the family must meet the Individual Deductible until the Family Deductible is met. Once an individual meets the Individual Deductible, Sharp Health Plan will pay for services for that individual in the family. Once the Family Deductible is met, Sharp Health Plan will pay for services for the entire family. All family members have met the Family Out-of-Pocket Maximum when the family's combined deductibles, copayments, and coinsurance equal the Family Out-of-Pocket Maximum.
11. Copayment depends on type and location of service.
12. Refers to procedure code D2140
13. Refers to procedure code D3330
14. Refers to procedure code D0999
15. Maximum member responsibility.
16. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; substance use disorder transitional residential recovery services in a non-medical residential recovery setting; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for pervasive developmental disorder (PDD) and autism.
17. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
18. Refers to procedure codes D0120 and D1120/D1110
19. Refers to procedure code D8080/D8090
20. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.

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(Footnotes continued from page 11)

† HSA Qualified High Deductible Plan

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/ services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Cost share amount varies based on type of services rendered and plan.

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