Employer

Program Guide

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 4/1/22

CaliforniaChoice®
Your Health. Your Choice.®

Anthem BlueCross · Cigna + oscar · health net · KAISER PERMANENTE · 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.

Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

ABOUT US

When we started CaliforniaChoice® in 1996, the idea of offering small businesses a program that provided their employees access to multiple health plans and benefits was truly revolutionary.

Now, with over twenty five years of innovation and experience, we're uniquely qualified to meet *and* exceed your needs by offering you the most Choice — at a price you can afford — while making the process effortless.

CaliforniaChoice®
Your Health. Your Choice.®

It's that **simple.**

Everything you and your employees want in a benefits program:

- **EIGHT HEALTH PLANS IN ONE**
- **COST CONTROL**
- **GREATER ACCESS TO DOCTORS, SPECIALISTS, AND HOSPITALS**
- **DENTAL, VISION, CHIROPRACTIC, AND LIFE BENEFITS**
- **BUSINESS SOLUTIONS SUITE**
- **MEMBER VALUE SUITE**
- **CONSOLIDATED BILLING**
- **SMART DECISION TECHNOLOGY**
- **SIMPLIFIED RENEWAL**

Incredible value. It's that **simple**.

EIGHT HEALTH PLANS IN ONE

Anthem BlueCross · Cigna + oscar · health net · KAISER PERMANENTE · SHARP HEALTH PLAN make life better · Sutter Health Plus Your Health Plan · UnitedHealthcare · Western Health Advantage

With CaliforniaChoice®, **each employee** can choose **any one of eight health plans** that best meets his or her unique personal and family needs.

For example, one of your employees might choose a PPO from Anthem Blue Cross because of a particular doctor or hospital in their network, while another employee who rarely visits the doctor might choose an HMO from Kaiser Permanente. A third employee might choose an HSA-compatible HMO from Western Health Advantage because of cost and tax considerations. Whatever your employees' needs may be, it's their Choice!

Offering this level of Choice — without increasing your cost versus a single health plan solution — gives you a recruiting advantage and a powerful tool to retain your current employees.

COST CONTROL

Controlling costs is easy with **Defined Contribution** because you choose how much to contribute.

Contribute a **Fixed Percentage** (50% to 100%) of a specific plan and/or benefit, **or** you can choose to contribute a **Fixed Dollar Amount** for each employee. Your employees then apply your generous contribution to whichever health plan and benefits they prefer. If an employee selects a plan that costs more than your contribution, he or she simply pays the difference.

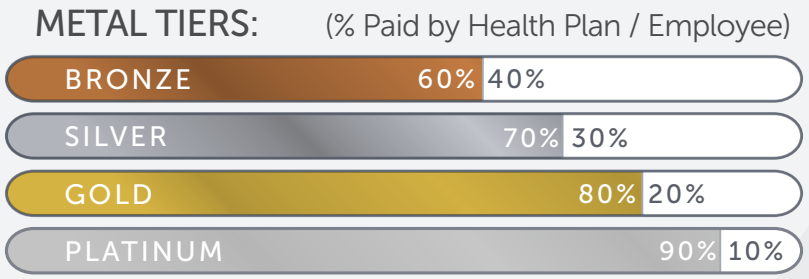
And when you renew with CaliforniaChoice, you have the option to adjust your contribution up or down, giving you complete control over what you spend on employee benefits.

PROGRAM OVERVIEW

GREATER ACCESS TO DOCTORS, SPECIALISTS, AND HOSPITALS

Looking for a doctor? We offer a number of **full *and* limited networks** allowing you and your employees access to the doctors, specialists, and hospitals you want at the *best-possible price point*.

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



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

OPTIONAL BENEFITS

The following comprehensive **dental, vision, chiropractic**, and **life** benefits can be easily added to any CaliforniaChoice plan:

OPTIONAL BENEFITS	
DENTAL	**MetLife DHMO** offers $5 office visits and no charge for oral exams, x-rays and two cleanings per year.
	SmileSaver℠ DHMO offers office visits, oral exams, x-rays, and includes two free cleanings per year.
	Ameritas PPO benefits offer low deductibles that allow members to visit any dental provider they wish, in or out-of-network.
VISION	The **Voluntary Vision Program** offers comprehensive vision benefits and prescription eyewear.
CHIROPRACTIC	**Landmark Healthplan** offers chiropractic benefits including examinations, adjustments, and acupuncture.
LIFE AND AD&D	**Assurity Life Insurance Company** offers coverage amounts ranging from $10,000 to $100,000 and includes Accidental Death & Dismemberment and a living benefits provision.

BUSINESS SOLUTIONS SUITE

The Business Solutions Suite is included at **no extra charge** and offers your business access to the services below.

BUSINESS SOLUTIONS SUITE	
HR SUPPORT	**Mineral** offers you access to an online HR Support Center. Enjoy 24-hour access to an online Human Resources (HR) Support Center powered by Mineral HR. You can get HR alerts, download and customize employee handbooks, forms, and job descriptions at no cost.
FSA	**Flexible Spending Accounts (FSA)** allow employees to set aside a portion of their salary on a pre-tax basis to use for eligible FSA medical expenses like copays and prescriptions.
COBRA	**Cal-COBRA Billing:** Includes participant invoicing and collection, premium remittance, payment tracking, and processing eligibility changes for non-payment scenarios.
	Federal COBRA Billing: Same as above but as required for 20+ groups
POP*	**Premium Only Plans (POP)** allow employees to pay insurance premiums pre-tax. It also helps reduce your tax liability as an employer.

*Initial set-up is covered at no cost.

MEMBER VALUE SUITE

The Member Value Suite offers your employees outstanding savings on a range of wellness products and services as well as entertainment activities.

MEMBER VALUE SUITE	
DENTAL	**Dentegra® Smile Club** offers reduced fee dental care services and a network of more than 20,000 providers.
VISION	**EyeMed Vision One Eyecare Discount Program** provided by Ameritas offers discounts on frames, lenses, and eye examinations at many locations including Sears, Pearle Vision, LensCrafters, and Target.
HEARING	**EPIC Hearing** offers discounts up to 50% on hearing-related products, hearing tests, and more.
EMPLOYEE DISCOUNTS	**Cal Perks Discount Program** offers discounts on movies, theme parks, hotels, and more.
RX DISCOUNTS	The **California Rx Card® Program** offers discounts of up to 75% on prescriptions – often reducing your cost to less than your Rx co-pay with insurance.
FITNESS AND WELLNESS DISCOUNTS	The **ChooseHealthy® Program** offers discounts of up to 57% on Garmin®, Vitamix®, and Fitbit® products, and fitness memberships for $25/month.

PROGRAM OVERVIEW

CONSOLIDATED BILLING

Whether you have one employee or 100, you'll get **a single, consolidated monthly bill** that lists all coverage levels, your contribution, and employee deductions. You can also pay your bill and manage your employee benefits online at **calchoice.com**.

Smart Decision Technology

Plan Comparison Tool – a tool that gives members the power to compare health plans – not just based on your premium but also cost, benefit type, and quality.

Online Enrollment (OLE) – Go paperless and enroll your business online. It will help eliminate incomplete applications, reduce the number of pending items, and decrease processing time. Traditional paper-based enrollment is also still available – it's completely up to you. The choice is yours.

Online provider search tool – employees can find the health plans and benefits associated with their favorite doctor, look for a new doctor, or even search hospital and network affiliations.

Online Rx search tool – employees can search for their prescriptions and identify exactly which health care coverage they need.

Renewal Is Simple Too!

During your annual renewal period, employees can switch health plans and/or benefits without leaving CaliforniaChoice®. *And you can change your contribution level depending on your company's changing financial picture – you decide what you want to spend.*

THREE STEPS TO ENROLL

1 CHOOSE TOTAL CHOICE (FOUR TIERS), OR CHOOSE TRIPLE, DOUBLE, OR SINGLE CHOICE

Total Choice – Offers employees access to the health plans and benefits available in all **four tiers**.

Triple Choice – Offers employees access to health plans and benefits available in **three neighboring tiers**.

Double Choice – Offers employees access to health plans and benefits available in **two neighboring tiers**.

Single Choice – Offers employees access to health plans and benefits available in a **single tier**.

Offers employees access to the health plans and benefits available in all four tiers.

- Bronze, Silver, Gold, Platinum

Offers employees access to health plans and benefits available in three neighboring tiers.

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

Offers employees access to health plans and benefits available in two neighboring tiers.

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

Offers employees access to health plans and benefits available in a single tier.

- Bronze
- Silver
- Gold
- Platinum

2 DEFINE YOUR MONTHLY CONTRIBUTION

Your broker will share plan premium information with you. Select your preferred plan and whether you want to pay a **Fixed Percentage** of costs (select from 50% to 100%) or a **Fixed Dollar Amount** toward that plan (for more information about Defined Contribution, please see page 5).

3 EMPLOYEES SELECT THEIR BENEFITS

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

On the following pages you'll find a brief summary of the benefits offered in each metal tier.

For more detailed benefit summaries, please contact your broker or visit ***calchoice.com****.*

BENEFIT HIGHLIGHTS

PlatinumHMO

Groups Beginning 4/1/22

Medical Benefits	HMO A‡	HMO C	HMO D	HMO E
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net	Health Net
Network Name	Select HMO	WholeCare	Salud HMO y Mas	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None	None
Dr. Office Visits (PCP)	$20 Copay	$30 Copay	$30 Copay	$30 Copay
Hospital Services - In-Patient	$300 Copay per day – 3 days max per admit	$600 Copay per day – 4 days max	$600 Copay per day – 4 days max	$600 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$250 Copay	$250 Copay	$250 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $5 Copay / Level 2 $15 Copay [16] Level 1 $20 Copay / Level 2 $30 Copay [16]	$5 Copay [3, 4] $30 Copay [3, 4]	$5 Copay [3, 4] $30 Copay [3, 4]	$5 Copay [3, 4] $30 Copay [3, 4]
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [6]	$2,500 / $5,000	$2,500 / $5,000 [2]	$2,500 / $5,000
Out-Patient Surgical Facility	$250 Copay	$500 Copay	$500 Copay	$500 Copay
Ambulance (per trip)	$150 Copay [15]	$250 Copay	$250 Copay	$250 Copay

Medical Benefits	HMO F	HMO G	HMO H
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	Salud HMO y Mas	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	100%	100%	100%
Hospital Services - In-Patient	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay	$250 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	100% [3, 4] $30 Copay [3, 4]	100% [3, 4] $30 Copay [3, 4]	100% [3, 4] $30 Copay [3, 4]
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000	$3,000 / $6,000 [2]	$3,000 / $6,000
Out-Patient Surgical Facility	$500 Copay	$500 Copay	$500 Copay
Ambulance (per trip)	$250 Copay	$250 Copay	$250 Copay

(Footnotes on page 44)

Medical Benefits	HMO A	HMO B	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp
Network Name	Full	Full	Premier
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$10 Copay	$20 Copay	$15 Copay
Hospital Services - In-Patient	$500 Copay per admit	$250 Copay per day – 5 days max	$400 Copay
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$200 Copay	$150 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay $15 Copay	$5 Copay $20 Copay	$10 Copay $25 Copay
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000	$4,500 / $9,000	$3,600 / $7,200 [5]
Out-Patient Surgical Facility	$300 Copay per procedure	$125 Copay per procedure	80%
Ambulance (per trip)	$150 Copay	$150 Copay	$150 Copay

Medical Benefits	HMO B	HMO C	HMO A	HMO B
Participating Health Plans	Sharp	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Premier	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Platinum**	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None	None
Dr. Office Visits (PCP)	$15 Copay	$10 Copay	$20 Copay [9]	$15 Copay [9]
Hospital Services - In-Patient	85%	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit	$250 Copay per day – 5 days max per admit
In-Patient Physician Fees	85%	100%	100%	100%
Emergency Room (copay waived if admitted)	85%	$200 Copay	$150 Copay	$100 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay $25 Copay	$10 Copay $25 Copay	$5 Copay [10, 11] $20 Copay [10, 11]	$5 Copay [10, 11] $15 Copay [10, 11]
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000 [5]	$4,000 / $8,000 [5]	$4,500 / $9,000 [12]	$3,500 / $7,000 [12]
Out-Patient Surgical Facility	85%	80%	$100 Copay	$100 Copay
Ambulance (per trip)	85%	$200 Copay	$150 Copay	$100 Copay

(Footnotes on page 44)

BENEFIT HIGHLIGHTS

PlatinumHMO

Groups Beginning 4/1/22

Medical Benefits	HMO A	HMO C	HMO E
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$25 Copay	$25 Copay	$20 Copay
Hospital Services - In-Patient	80%	80%	$400 Copay per day – 5 days max per admit
In-Patient Physician Fees	80%	80%	100%
Emergency Room (copay waived if admitted)	80%	80%	$400 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay[7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay[7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay[7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay[7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay[7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay[7]
Out-of-Pocket Max Ind/Fam	$3,500 / $7,000[8]	$3,500 / $7,000[8]	$3,000 / $6,000[8]
Out-Patient Surgical Facility	80%	80%	80%
Ambulance (per trip)	$100 Copay	$100 Copay	$100 Copay

Medical Benefits	HMO G	HMO H	HMO I
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	Harmony
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$20 Copay	$25 Copay	$20 Copay
Hospital Services - In-Patient	$400 Copay per day – 5 days max per admit	80%	$400 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	80%	100%
Emergency Room (copay waived if admitted)	$400 Copay	80%	$400 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay[7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay[7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay[7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay[7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay[7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay[7]
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000[8]	$3,500 / $7,000[8]	$3,000 / $6,000[8]
Out-Patient Surgical Facility	$250 Copay	80%	$250 Copay
Ambulance (per trip)	$100 Copay	$100 Copay	$100 Copay

(Footnotes on page 44)

Medical Benefits	HMO J	HMO K	HMO L
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	SignatureValue
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	100%	100%	100%
Hospital Services - In-Patient	80%	80%	80%
In-Patient Physician Fees	80%	80%	80%
Emergency Room (copay waived if admitted)	80%	80%	80%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [7] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [7]
Out-of-Pocket Max Ind/Fam	$4,500 / $9,000 [8]	$4,500 / $9,000 [8]	$4,500 / $9,000 [8]
Out-Patient Surgical Facility	80%	80%	80%
Ambulance (per trip)	$100 Copay	$100 Copay	$100 Copay

Medical Benefits	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$25 Copay	$20 Copay	$20 Copay
Hospital Services - In-Patient	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5	100%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$150 Copay	$150 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay $30 Copay [13]	$5 Copay $20 Copay [13]	$5 Copay $30 Copay [13]
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$4,500 / $9,000 [1]	$4,000 / $8,000 [1]
Out-Patient Surgical Facility	$100 Copay	$100 Copay	$100 Copay
Ambulance (per trip)	100%	$150 Copay	100%

(Footnotes on page 44)

BENEFIT HIGHLIGHTS

PlatinumEPO

Groups Beginning 4/1/22

Medical Benefits	EPO C	EPO D	EPO E
Participating Health Plans	Cigna + Oscar	Cigna + Oscar	Cigna + Oscar
Network Name	LocalPlus	LocalPlus	LocalPlus
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	$250 / $500 (combined Med/Pediatric dental ded) (applies to Max OOP)	$500 / $1,000 (combined Med/ Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$10 Copay	$15 Copay (ded waived)	$20 Copay (ded waived)
Hospital Services - In-Patient	$250 Copay per day - 5 days max	90%	85%
In-Patient Physician Fees	90%	90%	85%
Emergency Room (copay waived if admitted)	$250 Copay	$200 Copay	$250 Copay (ded waived)
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay $30 Copay	$5 Copay (overall ded waived) $30 Copay (overall ded waived)	$10 Copay (overall ded waived) $35 Copay (overall ded waived)
Out-of-Pocket Max Ind/Fam	$4,600 / $9,200	$4,500 / $9,000	$3,500 / $7,000
Out-Patient Surgical Facility	$250 Copay	90%	85%
Ambulance (per trip)	$250 Copay	$200 Copay	$350 Copay (ded waived)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

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

BENEFIT HIGHLIGHTS
GoldHMO
Groups Beginning 4/1/22

Medical Benefits	HMO A ‡	HMO B ‡	HMO C ‡	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	Priority Select HMO	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None	None
Dr. Office Visits (PCP)	$30 Copay	$30 Copay	$30 Copay	$30 Copay
Hospital Services - In-Patient	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit	$550 Copay per day – 4 days max per admit	$750 Copay per day – 3 days max
In-Patient Physician Fees	100%	100%	100%	100%
Emergency Room (copay waived if admitted)	$325 Copay	$325 Copay	$325 Copay	$300 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $10 Copay / Level 2 $20 Copay [21] Level 1 $50 Copay / Level 2 $60 Copay [21]	Level 1 $10 Copay / Level 2 $20 Copay [21] Level 1 $50 Copay / Level 2 $60 Copay [21]	Level 1 $10 Copay / Level 2 $20 Copay [21] Level 1 $50 Copay / Level 2 $60 Copay [21]	$15 Copay [2, 4] $50 Copay [2, 4]
Out-of-Pocket Max Ind/Fam	$6,250 / $12,500 [15]	$6,250 / $12,500 [15]	$6,250 / $12,500 [15]	$6,000 / $12,000
Out-Patient Surgical Facility	$500 Copay	$500 Copay	$500 Copay	$900 Copay
Ambulance (per trip)	$150 Copay [3]	$150 Copay [3]	$150 Copay [3]	$300 Copay

Medical Benefits	HMO B	HMO C	HMO D	HMO E
Participating Health Plans	Health Net	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	Salud HMO y Mas	Full
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None	None
Dr. Office Visits (PCP)	$40 Copay	$35 Copay	$35 Copay	$35 Copay
Hospital Services - In-Patient	$750 Copay per day – 5 days max	$750 Copay per day – 4 days max	$750 Copay per day – 4 days max	$750 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%	100%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$300 Copay	$300 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay [2, 4] $50 Copay [2, 4]	$15 Copay [2, 4] $50 Copay [2, 4]	$15 Copay [2, 4] $50 Copay [2, 4]	$15 Copay [2, 4] $50 Copay [2, 4]
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000	$6,500 / $13,000	$6,500 / $13,000 [22]	$6,500 / $13,000
Out-Patient Surgical Facility	$1,200 Copay	$1,200 Copay	$1,200 Copay	$1,200 Copay
Ambulance (per trip)	$300 Copay	$300 Copay	$300 Copay	$300 Copay

(Footnotes on page 19)

BENEFIT HIGHLIGHTS

GoldHMO

Groups Beginning 4/1/22

Medical Benefits	HMO F‡	HMO G	HMO B	HMO C
Participating Health Plans	Health Net	Health Net	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$250 / $500 [6] (applies to Max OOP)	None
Dr. Office Visits (PCP)	$40 Copay	$30 Copay	$35 Copay (ded waived)	$30 Copay
Hospital Services - In-Patient	$750 Copay per day – 5 days max	$750 Copay per day – 3 days max	$600 Copay per day – 5 days max	$600 Copay per day – 5 days max
In-Patient Physician Fees	100%	100%	100% (ded waived)	100%
Emergency Room (copay waived if admitted)	$300 Copay	$300 Copay	$250 Copay	$250 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay [2, 4] $50 Copay [2, 4]	$15 Copay [2, 4] $50 Copay [2, 4]	$15 Copay (overall ded waived) $40 Copay (overall ded waived)	$15 Copay $40 Copay
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000	$6,000 / $12,000	$7,800 / $15,600 [7]	$7,000 / $14,000 [7]
Out-Patient Surgical Facility	$1,200 Copay	$900 Copay	$335 Copay per procedure	$320 Copay per procedure
Ambulance (per trip)	$300 Copay	$300 Copay	$250 Copay	$250 Copay

Medical Benefits	HMO D	HMO E‡ HSA Qualified	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Full	Performance	Premier
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,000 / $2,000 [6] (applies to Max OOP)	$1,600 / $2,800 / 3,200 [9, 23] (combined Med/Rx ded) (applies to Max OOP)	None	None
Dr. Office Visits (PCP)	$40 Copay (ded waived)	85%	$20 Copay	$25 Copay
Hospital Services - In-Patient	$600 Copay per day – 5 days max	85%	70%	$600 Copay per day – 5 days max
In-Patient Physician Fees	100% (ded waived)	85%	70%	100%
Emergency Room (copay waived if admitted)	$350 Copay (ded waived)	85%	70%	$400 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$20 Copay (ded waived) $250 / $500 Ded - $50 Copay	$15 Copay (combined Med/Rx ded) $45 Copay (combined Med/Rx ded)	$16 Copay (ded waived) $200 / $400 Ded – $35 Copay	$16 Copay (ded waived) $400 / $800 Ded – $40 Copay
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [7]	$3,250 / $6,500 [9]	$8,000 / $16,000 [5]	$8,000 / $16,000 [5]
Out-Patient Surgical Facility	$350 Copay per procedure (ded waived)	85%	70%	75%
Ambulance (per trip)	$350 Copay (ded waived)	85%	70%	$200 Copay

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Medical Benefits	HMO D	HMO A	HMO B
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Performance	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$1,500 / $3,000 [10] (applies to Max OOP)	$250 / $500 [10] (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay	$30 Copay [11]	$35 Copay (ded waived) [11]
Hospital Services - In-Patient	$1,500 Copay	80%	$600 Copay per day – 5 days max per admit
In-Patient Physician Fees	100%	80%	100% (ded waived)
Emergency Room (copay waived if admitted)	$300 Copay	$150 Copay	$250 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$16 Copay $35 Copay	$5 Copay (overall ded waived) [12, 13] $15 Copay (overall ded waived) [12, 13]	$15 Copay (overall ded waived) [12, 13] $40 Copay (overall ded waived) [12, 13]
Out-of-Pocket Max Ind/Fam	$6,650 / $13,300 [5]	$4,000 / $8,000 [14]	$7,800 / $15,600 [14]
Out-Patient Surgical Facility	$600 Copay per procedure	80%	$300 Copay
Ambulance (per trip)	$200 Copay	$150 Copay	$250 Copay

Medical Benefits	HMO A	HMO B	HMO F	HMO G
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,250 / $2,500 [20] (applies to Max OOP)	$1,250 / $2,500 [20] (applies to Max OOP)	None	None
Dr. Office Visits (PCP)	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay	$35 Copay
Hospital Services - In-Patient	70%	70%	$800 Copay per day – 5 days max per admit	$800 Copay per day – 5 days max per admit
In-Patient Physician Fees	70% (ded waived)	70% (ded waived)	100%	100%
Emergency Room (copay waived if admitted)	70%	70%	$500 Copay	$500 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [8] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [8] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $10 Copay / Tier 1 Specialty $10 Copay (ded waived) [8] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $10 Copay / Tier 1 Specialty $10 Copay (ded waived) [8] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000 [9]	$8,000 / $16,000 [9]	$7,000 / $14,000 [9]	$7,000 / $14,000 [9]
Out-Patient Surgical Facility	70%	70%	$500 Copay	$500 Copay
Ambulance (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay	$100 Copay

(Footnotes on page 19)

BENEFIT HIGHLIGHTS

GoldHMO

Groups Beginning 4/1/22

Medical Benefits	HMO H	HMO J	HMO L	HMO M
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Harmony	Harmony
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$500 / $1,000 [20] (applies to Max OOP)	$500 / $1,000 [20] (applies to Max OOP)	$1,250 / $2,500 [20] (applies to Max OOP)	None
Dr. Office Visits (PCP)	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay
Hospital Services - In-Patient	80%	80%	70%	$800 Copay per day – 5 days max per admit
In-Patient Physician Fees	80%	80%	70% (ded waived)	100%
Emergency Room (copay waived if admitted)	$500 Copay	$500 Copay	70%	$500 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [8] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [8] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [8] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $10 Copay / Tier 1 Specialty $10 Copay (ded waived) [8] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000 [9]	$7,500 / $15,000 [9]	$8,000 / $16,000 [9]	$7,000 / $14,000 [9]
Out-Patient Surgical Facility	80%	80%	70%	$500 Copay
Ambulance (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay

Medical Benefits	HMO N	HMO O	HMO P	HMO Q
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Harmony	Alliance	Harmony	SignatureValue
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$500 / $1,000 [20] (applies to Max OOP)	$2,000 / $4,000 [20] (applies to Max OOP)	$2,000 / $4,000 [20] (applies to Max OOP)	$2,000 / $4,000 [20] (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay (ded waived)	100% (ded waived)	100% (ded waived)	100% (ded waived)
Hospital Services - In-Patient	80%	60%	60%	60%
In-Patient Physician Fees	80%	60% (ded waived)	60% (ded waived)	60% (ded waived)
Emergency Room (copay waived if admitted)	$500 Copay	60%	60%	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [8] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay (ded waived) [8] $250 / $500 Ded - Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay (ded waived) [8] $250 / $500 Ded - Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay (ded waived) [8] $250 / $500 Ded - Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000 [9]	$8,500 / $17,000 [9]	$8,500 / $17,000 [9]	$8,500 / $17,000 [9]
Out-Patient Surgical Facility	80%	60% (ded waived)	60% (ded waived)	60% (ded waived)
Ambulance (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay (ded waived)

BENEFIT HIGHLIGHTS
GoldHMO
Groups Beginning 4/1/22

Medical Benefits	HMO A	HMO B	HMO C	HMO D † HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$250 / $500[16, 17] (applies to Max OOP)	$1,000 / $2,000[16, 17] (applies to Max OOP)	$2,400 / $2,800 / $4,800[16, 17, 18] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$40 Copay	$35 Copay (ded waived)	$40 Copay (ded waived)	100%[16]
Hospital Services - In-Patient	$600 Copay per day	$600 Copay per day[16] – Days 1-5	$500 Copay per day[16] – Days 1-5	100%[16]
In-Patient Physician Fees	100%	100% (ded waived)	100% (ded waived)	100%[16]
Emergency Room (copay waived if admitted)	$300 Copay	$250 Copay[16]	$300 Copay[16]	100%[16]
Rx Benefits - Generic Rx Benefits - Formulary Brand	$20 Copay $50 Copay[19]	$15 Copay (overall ded waived) $40 Copay (overall ded waived)[19]	$10 Copay (ded waived) $500 / $1,000 Ded – $50 Copay[16, 19]	100% (combined Med/Rx ded)[16] $30 Copay (combined Med/Rx ded)[16, 19]
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500[1]	$7,800 / $15,600[1, 17]	$6,750 / $13,500[1, 17]	$4,800 / $9,600[1, 17]
Out-Patient Surgical Facility	$300 Copay	$300 Copay[16]	$500 Copay[16]	100%[16]
Ambulance (per trip)	100%	$250 Copay[16]	100% (ded waived)	100%[16]

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† A Health Savings (HSA)-qualified plan is a high-deductible health plan that offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified medical expenses with tax-advantaged dollars

‡ This plan includes certain Infertility benefits; please see the CaliforniaChoice® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

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

1. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
2. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
3. Medical emergency only
4. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
5. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
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. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.
9. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
10. 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 2022 plans.
11. 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.

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BENEFIT HIGHLIGHTS

GoldPPO

Groups Beginning 4/1/22

Medical Benefits	PPO A ‡		PPO B ‡	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Advantage PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [6]	In-Network	Out-of-Network [6]
Calendar Year Deductible*	$500 / $1,500 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,000 / $3,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$25 Copay (ded waived)	50%
Hospital Services - In-Patient	Tier 1: 80% Tier 2: $500 Copay per admit – 80%	50% (up to $650 per day) [4]	75%	50% (up to $650 per day) [4]
In-Patient Physician Fees	80%	50%	75%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%	$250 Copay – 80%	$250 Copay – 75%	$250 Copay – 75%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [1] $250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay [1]	Not Covered Not Covered	Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [1] $250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [3]	$15,600 / $31,200 [3]	$7,800 / $15,600 [3]	$15,600 / $31,200 [3]
Out-Patient Surgical Facility	Tier 1: 80% Tier 2: $250 Copay per admit – 80%	50% (up to $380 per admit) [4]	$200 Copay per admit – 75%	50% (up to $380 per admit) [4]
Ambulance (per trip)	80% [5]	80% [5]	75% [5]	75% [5]

Medical Benefits	PPO C ‡		PPO D ‡	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Select PPO	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [6]	In-Network	Out-of-Network [6]
Calendar Year Deductible*	$500 / $1,500 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,500 / $3,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,000 / $6,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Hospital Services - In-Patient	80%	50% (up to $650 per day) [4]	75%	50% (up to $650 per day) [4]
In-Patient Physician Fees	80%	50%	75%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%	$250 Copay – 80%	$250 Copay – 75%	$250 Copay – 75%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [1] $150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay [1]	Not Covered Not Covered	Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [1] $250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$7,700 / $15,400 [3]	$15,400 / $30,800 [3]	$8,000 / $16,000 [3]	$16,000 / $32,000 [3]
Out-Patient Surgical Facility	$200 Copay per admit – 80%	50% (up to $380 per admit) [4]	$200 Copay per admit – 75%	50% (up to $380 per admit) [4]
Ambulance (per trip)	80% [5]	80% [5]	75% [5]	75% [5]

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Medical Benefits	PPO E ‡	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer - Small Group	
Metal Tier	**Gold**	
	In-Network	Out-of-Network [6]
Calendar Year Deductible*	$500 / $1,500 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,000 / $4,000 [2] (combined Med/Pediatric dental ded) (applies to Max OOP
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%
Hospital Services - In-Patient	80%	50% (up to $650 per day) [4]
In-Patient Physician Fees	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 80%	$250 Copay – 80%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [1] $150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$7,700 / $15,400 [3]	$15,400 / $30,800 [3]
Out-Patient Surgical Facility	$200 Copay per admit – 80%	50% (up to $380 per admit) [4]
Ambulance (per trip)	80% [5]	80% [5]

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Medical Benefits	EPO C	EPO D	EPO E
Participating Health Plans	Cigna + Oscar	Cigna + Oscar	Cigna + Oscar
Network Name	LocalPlus	LocalPlus	LocalPlus
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$1,350 / $2,700 (combined Med/Pediatric dental ded) (applies to Max OOP)	$750 / $1,500 (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay	$45 Copay (ded waived)	$30 Copay (ded waived)
Hospital Services - In-Patient	$750 Copay per day – 5 days max	80%	60%
In-Patient Physician Fees	70%	80%	80%
Emergency Room (copay waived if admitted)	$450 Copay	$550 Copay	$550 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay $40 Copay	$15 Copay (ded waived) $300 / $600 Ded - $45 Copay	$15 Copay (ded waived) $300 / $600 Ded - $45 Copay
Out-of-Pocket Max Ind/Fam	$8,700 / $17,400	$8,550 / $17,100	$8,550 / $17,100
Out-Patient Surgical Facility	$350 Copay	80%	80%
Ambulance (per trip)	$450 Copay	$550 Copay	$550 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.
* All services are subject to the deductible unless otherwise stated.

BENEFIT HIGHLIGHTS

SilverHMO

Groups Beginning 4/1/22

Medical Benefits	HMO A ‡	HMO B ‡	HMO C ‡	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	Priority Select HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,200 / $4,400 [25] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,200 / $4,400 [25] (combined Med/Pediatric dental ded) (applies to Max OOP)	$2,200 / $4,400 [25] (combined Med/Pediatric dental ded) (applies to Max OOP)	None
Dr. Office Visits (PCP)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay
Hospital Services - In-Patient	55%	55%	55%	50%
In-Patient Physician Fees	100% (ded waived)	100% (ded waived)	100% (ded waived)	50%
Emergency Room (copay waived if admitted)	$350 Copay – 55%	$350 Copay – 55%	$350 Copay – 55%	50%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [8] $300 / $600 Ded – Level 1 $70 Copay / Level 2 $80 Copay [8]	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [8] $300 / $600 Ded – Level 1 $70 Copay / Level 2 $80 Copay [8]	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [8] $300 / $600 Ded – Level 1 $70 Copay / Level 2 $80 Copay [8]	$20 Copay (ded waived) [11, 23] $750 / $1,500 Ded – 50% (up to $250 per prescription [21]) [11, 23]
Out-of-Pocket Max Ind/Fam	$8,700 / $17,400 [26]	$8,700 / $17,400 [26]	$8,700 / $17,400 [26]	$7,950 / $15,900
Out-Patient Surgical Facility	55%	55%	55%	50%
Ambulance (per trip)	55% [24]	55% [24]	55% [24]	50%

Medical Benefits	HMO C	HMO A	HMO B	HMO C
Participating Health Plans	Health Net	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	CommunityCare	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,750 / $3,500 (applies to Max OOP)	$2,100 / $4,200 [5] (applies to Max OOP)	$1,650 / $3,300 [5] (applies to Max OOP)	$2,250 / $4,500 [5] (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services - In-Patient	60%	55%	60%	70%
In-Patient Physician Fees	60%	55%	60%	70%
Emergency Room (copay waived if admitted)	60%	55%	60%	70%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay (ded waived) [11, 23] $250 / $500 Ded – 60% (up to $250 per prescription [21]) [11, 23]	$20 Copay (ded waived) $500 / $1,000 Ded - $75 Copay	$20 Copay (ded waived) $350 / $700 Ded – $75 Copay	$17 Copay (ded waived) $300 / $600 Ded – $80 Copay
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600	$8,200 / $16,400 [6]	$8,200 / $16,400 [6]	$8,200 / $16,400 [6]
Out-Patient Surgical Facility	60%	55%	60%	70%
Ambulance (per trip)	$300 Copay	55%	60%	70%

(Footnotes on page 25)

BENEFIT HIGHLIGHTS
SilverHMO
Groups Beginning 4/1/22

Medical Benefits	HMO D† HSA Qualified	HMO E	HMO A	HMO B
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Full	Premier	Performance
Metal Tier	**Silver**	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,500 / $2,800 / $5,000 [5, 18] (combined Med/Rx ded) |(applies to Max OOP)	$2,600 / $5,200 [5] (combined Med/Rx ded)(applies to Max OOP)	$2,300 / $4,600 [4] (applies to Max OOP)	$2,300 / $4,600 [4] (applies to Max OOP)
Dr. Office Visits (PCP)	80%	$55 Copay (ded waived)	$40 Copay (ded waived)	$40 Copay (ded waived)
Hospital Services - In-Patient	80%	55%	$975 Copay per day	60%
In-Patient Physician Fees	80%	55%	100%	60%
Emergency Room (copay waived if admitted)	80%	55%	$750 Copay	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	80% (combined Med/Rx ded) 80% (combined Med/Rx ded)	$20 Copay (ded waived) $75 Copay (combined Med/Rx ded)	$16 Copay (ded waived) $250 / $ $500 Ded – $105 Copay	$16 Copay (ded waived) $250 / $500 Ded – $100 Copay
Out-of-Pocket Max Ind/Fam	$6,850 / $13,700 [6]	$8,200 / $16,400 [6]	$8,500 / $17,000 [4, 22]	$8,550 / $17,100 [4, 22]
Out-Patient Surgical Facility	80%	55%	50%	60%
Ambulance (per trip)	80%	55%	$400 Copay (ded waived)	60% (ded waived)

Medical Benefits	HMO C	HMO B	HMO C† HSA Qualified
Participating Health Plans	Sharp	Sutter Health Plus	Sutter Health Plus
Network Name	Premier	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,500 / $5,000 [4] (applies to Max OOP)	$2,250 / $4,500 [12] (applies to Max OOP)	$2,500 / $2,800 / $5,000 [12, 17] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$55 Copay (ded waived) [13]	$35 Copay [13]
Hospital Services - In-Patient	50%	70%	80%
In-Patient Physician Fees	50%	70% (ded waived)	80%
Emergency Room (copay waived if admitted)	50%	70%	80%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$16 Copay (overall ded waived) $100 Copay (overall ded waived)	$17 Copay (ded waived) [14, 15] $300 / $600 Ded – $80 Copay [14, 15]	$10 Copay (combined Med/Rx ded) [14, 15] $20 Copay (combined Med/Rx ded) [14, 15]
Out-of-Pocket Max Ind/Fam	$8,550 / $17,100 [4, 22]	$8,200 / $16,400 [16]	$6,850 / $13,700 [16]
Out-Patient Surgical Facility	50%	70%	80%
Ambulance (per trip)	50% (ded waived)	70%	80%

(Footnotes on page 25)

BENEFIT HIGHLIGHTS

SilverHMO

Groups Beginning 4/1/22

Medical Benefits	HMO A	HMO E
Participating Health Plans	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,350 / $4,700 [7] (applies to Max OOP)	$2,350 / $4,700 [7] (applies to Max OOP)
Dr. Office Visits (PCP)	$55 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services - In-Patient	60%	60%
In-Patient Physician Fees	60% (ded waived)	60% (ded waived)
Emergency Room (copay waived if admitted)	60%	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [9] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [9]	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [9] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [9]
Out-of-Pocket Max Ind/Fam	$8,700 / $17,400 [10]	$8,700 / $17,400 [10]
Out-Patient Surgical Facility	60%	60%
Ambulance (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)

Medical Benefits	HMO F	HMO G	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Harmony	Harmony	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,350 / $4,700 (applies to Max OOP) [7]	$2,350 / $4,700 (applies to Max OOP) [7]	$2,300 / $4,600 [1, 19] (applies to Max OOP)
Dr. Office Visits (PCP)	$55 Copay (ded waived)	60%	$50 Copay (ded waived)
Hospital Services - In-Patient	60%	60%	70% [1, 3]
In-Patient Physician Fees	60% (ded waived)	60%	100% (ded waived)
Emergency Room (copay waived if admitted)	60%	60%	70% [1, 3]
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $20 Copay / Tier 1 Specialty $20 Copay (ded waived) [9] $400 / $800 Ded – Tier 2 Non-specialty $80 Copay / Tier 2 Specialty $150 Copay [9]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [9] $400 / $800 Ded – Tier 2 Non-specialty $75 Copay / Tier 2 Specialty $150 Copay [9]	$15 Copay (ded waived) [9] $250 /$500 Ded – $55 Copay [1, 20]
Out-of-Pocket Max Ind/Fam	$8,700 / $17,400 [10]	$8,600 / $17,200 [10]	$8,000 / $16,000 [2, 19]
Out-Patient Surgical Facility	60%	60%	$350 Copay [1]
Ambulance (per trip)	$100 Copay (ded waived)	60%	100% (ded waived)

(Footnotes on page 25)

BENEFIT HIGHLIGHTS

SilverHMO

Groups Beginning 4/1/22

Medical Benefits	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,250 / $4,500 [1, 19] (applies to Max OOP)	$2,500 / $2,800 / $5,000 [1, 17, 19] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$55 Copay (ded waived)	80% [1, 3]
Hospital Services - In-Patient	70% [1, 3]	80% [1, 3]
In-Patient Physician Fees	70% (ded waived) [3]	80% [1, 3]
Emergency Room (copay waived if admitted)	70% [1, 3]	80% [1, 3]
Rx Benefits - Generic	$17 Copay (ded waived)	80% (up to $250 per 30 day supply [21]) (combined Med/Rx ded) [1, 3]
Rx Benefits - Formulary Brand	$300 / $600 Ded – $80 Copay [1, 20]	80% (up to $250 per 30 day supply [21]) (combined Med/Rx ded) [1, 3, 20]
Out-of-Pocket Max Ind/Fam	$8,200 / $16,400 [2, 19]	$6,850 / $13,700 [2, 19]
Out-Patient Surgical Facility	70% [1, 3]	80% [1, 3]
Ambulance (per trip)	70% [1, 3]	80% [1, 3]

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† A Health Savings Account (HSA)-qualified health plan is a high-deductible health plan that often offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified medical expenses with tax-advantaged dollars.

‡ This plan includes certain Infertility benefits; please see the CaliforniaChoice® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

* 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. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
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. 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.
6. 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.
7. 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.
8. 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.
9. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.
10. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
11. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
12. 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 2022 plans.

(Footnotes continued on page 45)

BENEFIT HIGHLIGHTS

SilverPPO

Groups Beginning 4/1/22

Medical Benefits	**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 [8]	In-Network	Out-of-Network [8]
Calendar Year Deductible*	$1,600 / $3,200 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,200 / $6,400 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$1,700 / $3,400 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,400 / $6,800 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$45 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Hospital Services - In-Patient	Tier 1: 60% Tier 2: $500 Copay per admit – 60%	50% (up to $650 per day) [4]	60%	50% (up to $650 per day) [4]
In-Patient Physician Fees	60%	50%	60%	50%
Emergency Room (copay waived if admitted)	$350 Copay – 60%	$350 Copay – 60%	$300 Copay – 60%	$300 Copay – 60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [1] $300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [1]	Not Covered Not Covered	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [1] $300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$8,700 / $17,400 [3]	$17,400 / $34,800 [3]	$8,300 / $16,600 [3]	$16,600 / $33,200 [3]
Out-Patient Surgical Facility	Tier 1: 60% Tier 2: $250 Copay per admit – 60%	50% (up to $380 per admit) [4]	$200 Copay per admit – 60%	50% (up to $380 per admit) [4]
Ambulance (per trip)	60% [5]	60% [5]	60% [5]	60% [5]

Medical Benefits	**PPO C ‡**	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Silver**	
	In-Network	Out-of-Network [8]
Calendar Year Deductible*	$1,700 / $3,400 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)	$3,400 / $6,800 [2] (combined Med/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	50%
Hospital Services - In-Patient	60%	50% (up to $650 per day) [4]
In-Patient Physician Fees	60%	50%
Emergency Room (copay waived if admitted)	$300 Copay – 60%	$300 Copay – 60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [1] $300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$8,300 / $16,600 [3]	$16,600 / $33,200 [3]
Out-Patient Surgical Facility	$200 Copay per admit – 60%	50% (up to $380 per admit) [4]
Ambulance (per trip)	60% [5]	60% [5]

(Footnotes on page 46)

Medical Benefits	EPO A ‡	EPO B †, ‡ HSA Qualified
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross
Network Name	Prudent Buyer – Small Group	Prudent Buyer – Small Group
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,200 / $4,400 [2] (combined Med/ Pediatric dental ded) (applies to Max OOP)	$2,000 / $2,800 / $4,000 [7] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	65%
Hospital Services - In-Patient	60%	65%
In-Patient Physician Fees	60%	65%
Emergency Room (copay waived if admitted)	$300 Copay – 60%	65%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [1] $300 / $600 Ded – Level 1 $70 Copay / Level 2 $80 Copay [1]	Level 1 $15 Copay / Level 2 $20 Copay (combined Med/Rx/ Pediatric dental ded) [1, 11] Level 1 $70 Copay / Level 2 $80 Copay (combined Med/Rx/ Pediatric dental ded) [1, 11]
Out-of-Pocket Max Ind/Fam	$8,700 / $17,400 [3]	$7,050 / $14,100 [3]
Out-Patient Surgical Facility	$200 Copay per admit – 60%	$200 Copay per admit – 65%
Ambulance (per trip)	60% [5]	65% [5]

Medical Benefits	EPO C	EPO D	EPO E † HSA Qualified
Participating Health Plans	Cigna + Oscar	Cigna + Oscar	Cigna + Oscar
Network Name	LocalPlus	LocalPlus	LocalPlus
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$1,950 / $3,900 (combined Med/ Pediatric dental ded) (applies to Max OOP)	$2,600 / $5,200 (combined Med/ Pediatric dental ded) (applies to Max OOP)	$2,500 / $2,800 / $5,000 [10] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	$55 Copay (ded waived)	70%
Hospital Services - In-Patient	65%	60%	70%
In-Patient Physician Fees	65%	60%	70%
Emergency Room (copay waived if admitted)	65%	60%	70%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$25 Copay (ded waived) $250 / $500 Ded - $75 Copay	$25 Copay (overall ded waived) $75 Copay (overall ded waived)	$20 Copay (combined Med/Rx/ Pediatric dental ded) $60 Copay (combined Med/Rx/ Pediatric dental ded)
Out-of-Pocket Max Ind/Fam	$8,700 / $17,400	$8,700 / $17,400	$7,000 / $14,000
Out-Patient Surgical Facility	$450 Copay	60%	70%
Ambulance (per trip)	65%	60%	70%

(Footnotes on page 46)

BENEFIT HIGHLIGHTS

BronzeHMO

Groups Beginning 4/1/22

Medical Benefits	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 [19] (applies to Max OOP)	$5,400 / $10,800 [19] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$65 Copay [17]	$65 Copay [17]	$60 Copay [17]
Hospital Services - In-Patient	60%	60%	50%
In-Patient Physician Fees	60%	60%	50%
Emergency Room (copay waived if admitted)	60%	60%	50%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$500 / $1,000 Ded – $18 Copay [27, 28] $500 / $1,000 Ded – 60% (up to $500 per prescription [18]) [27, 28]	$500 / $1,000 Ded – $18 Copay $500 / $1,000 Ded – 60% (up to $500 per prescription [18])	$20 Copay (ded waived) 50% (up to $500 per prescription [18]) (combined Med/Rx ded)
Out-of-Pocket Max Ind/Fam	$8,200 / $16,400	$8,200 / $16,400 [30]	$8,200 / $16,400 [30]
Out-Patient Surgical Facility	60%	60%	50%
Ambulance (per trip)	60%	60%	50%

Medical Benefits	HMO C † HSA Qualified	HMO A	HMO B † HSA Qualified
Participating Health Plans	Kaiser Permanente	Sharp	Sharp
Network Name	Full	Premier	Performance
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$7,000 / $14,000 [19] (combined Med/Rx ded) (applies to Max OOP)	$7,600 / $15,200 [4] (applies to Max OOP)	$6,200 / $12,400 [10] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	100%	$55 Copay	60%
Hospital Services - In-Patient	100%	$1,500 Copay per day – 3 days max	60%
In-Patient Physician Fees	100%	100%	60%
Emergency Room (copay waived if admitted)	100%	$500 Copay	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	100% (combined Med/Rx ded) 100% (combined Med/Rx ded)	$16 Copay (overall ded waived) $60 Copay (overall ded waived)	60% (up to $500 per prescription [18]) (combined Med/Rx ded) 60% (up to $500 per prescription [18]) (combined Med/Rx ded)
Out-of-Pocket Max Ind/Fam	$7,000/14,000 [30]	$7,950 / $15,900 [4, 24]	$6,900 / $13,800 [10, 24]
Out-Patient Surgical Facility	100%	60%	60%
Ambulance (per trip)	100%	$500 Copay	60%

(Footnotes on page 31)

Medical Benefits	HMO A	HMO B† HSA Qualified
Participating Health Plans	Sutter Health Plus	Sutter Health Plus
Network Name	Sutter Health Plus	Sutter Health Plus
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,300 / $12,600 [11] (applies to Max OOP)	$7,000 / $14,000 [11] (combined Med/Rx ded)(applies to Max OOP)
Dr. Office Visits (PCP)	$65 Copay [12, 13]	100% [12]
Hospital Services - In-Patient	60%	100%
In-Patient Physician Fees	60%	100%
Emergency Room (copay waived if admitted)	60%	100%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$500 / $1,000 Ded – $18 Copay [14, 15] $500 / $1,000 Ded – 60% (up to $500 per prescription [18]) [14, 15]	100% (combined Med/Rx ded) [14, 15] 100% (combined Med/Rx ded) [14, 15]
Out-of-Pocket Max Ind/Fam	$8,200 / $16,400 [16]	$7,000 / 14,000 [16]
Out-Patient Surgical Facility	60%	100%
Ambulance (per trip)	60%	100%

Medical Benefits	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, 8] (applies to Max OOP)	$7,000 / $14,000 [1, 8] (combined Med/Rx ded)(applies to Max OOP)
Dr. Office Visits (PCP)	$65 Copay [9]	100% [1]
Hospital Services - In-Patient	60% [1, 3]	100% [1]
In-Patient Physician Fees	60% [1, 3]	100% [1]
Emergency Room (copay waived if admitted)	60% [1, 3]	100% [1]
Rx Benefits - Generic Rx Benefits - Formulary Brand	$500 / $1,000 Ded – $18 Copay [1] $500 / $1,000 Ded – 60% (up to $500 per 30 day supply [18]) [1, 3, 22]	100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 22]
Out-of-Pocket Max Ind/Fam	$8,200 / $16,400 [2, 8]	$7,000 / $14,000 [2, 8]
Out-Patient Surgical Facility	60% [1, 3]	100% [1]
Ambulance (per trip)	60% [1, 3]	100% [1]

(Footnotes on page 31)

BENEFIT HIGHLIGHTS

BronzePPO & EPO

Groups Beginning 4/1/22

Medical Benefits	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 [20]	In-Network	Out-of-Network [20]
Calendar Year Deductible*	$6,250 / $12,500 [25] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$12,500 / $25,000 [25] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$6,250 / $12,500 [25] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)	$12,500 / $25,000 [25] (combined Med/Rx/Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	65%	50%	65%	50%
Hospital Services - In-Patient	65%	50% (up to $650 per day) [29]	65%	50% (up to $650 per day) [29]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%	65%	65%	65%
Rx Benefits - Generic	Level 1 $20 Copay / Level 2 $20 Copay (combined Med/Rx/ Pediatric dental ded) [23, 31]	Not Covered	Level 1 $20 Copay / Level 2 $20 Copay (combined Med/Rx/ Pediatric dental ded) [23, 31]	Not Covered
Rx Benefits - Formulary Brand	Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx/ Pediatric dental ded) [23, 31]	Not Covered	Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx/ Pediatric dental ded) [23, 31]	Not Covered
Out-of-Pocket Max Ind/Fam	$7,050 / $14,100 [26]	$14,100 / $28,200 [26]	$7,050 / $14,100 [26]	$14,100 / $28,200 [26]
Out-Patient Surgical Facility	$200 Copay per admit – 65%	50% (up to $380 per admit) [29]	$200 Copay per admit –65%	50% (up to $380 per admit) [29]
Ambulance (per trip)	65% [21]	65% [21]	65% [21]	65% [21]

Medical Benefits	EPO A ‡	EPO C † HSA Qualified	EPO D
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*	$6,000 / $12,000 [25] (combined Med/ Pediatric dental ded) (applies to Max OOP)	$5,750 / $11,500 (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)	$6,000 / $12,000 (combined Med/Rx/ Pediatric dental ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$65 Copay	60%	$80 Copay (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%	60%	60%
Rx Benefits - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived) [23]	60% (up to $250 per prescription [18]) (combined Med/Rx/Pediatric dental ded)	$35 Copay (ded waived)
Rx Benefits - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay [23]	60% (up to $250 per prescription [18]) (combined Med/Rx/Pediatric dental ded)	60%% (up to $250 per prescription [18]) (combined Med/Rx/Pediatric dental ded)
Out-of-Pocket Max Ind/Fam	$8,500 / $17,000 [26]	$7,000 / $14,000	$8,700 / $17,400
Out-Patient Surgical Facility	$200 Copay per admit – 60%	60%	60%
Ambulance (per trip)	60% [21]	60%	60%

(Footnotes on page 31)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† A Health Savings Account (HSA)-qualified health plan is a high-deductible health plan that often offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified medical expenses with tax-advantaged dollars.

‡ This plan includes certain Infertility benefits; please see the CaliforniaChoice® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

* 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. Percentage copayment amounts are based on WHA's contracted rates with the provider of service.
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. 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. For Specialty drugs, please see plan specific EOC.
7. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
8. 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.
9. Deductible waived for first two non-preventive care visits (PCP, Mental Health and Substance Abuse combined).
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. 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 2022 plans.
12. 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.
13. 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.
14. 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.
15. 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.
16. 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.
17. Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behaviroal health and substance use disorder services).
18. Maximum member responsibility.
19. 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.
20. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.

(Footnotes continued on page 46)

OPTIONAL BENEFITS AND BUSINESS SOLUTIONS SUITE

At CaliforniaChoice®, we are committed to providing your business and your employees with more than just access to great health plan choices and the ability to control your costs.

The **Member Value Suite** offers your employees outstanding savings on a range of wellness products and services as well as entertainment activities.

The **Business Solutions Suite** saves you money and delivers valuable benefits for your business and your employees.

Both the **Member Value Suite** and **Business Solutions Suite** are available to you and your employees at no added cost.

Included in the Member Value Suite

Included in the Business Solutions Suite

Vision

Dental

Online HR Support

Hearing

Rx Discounts

COBRA Billing

Fitness and Wellness Discounts

Employee Discounts

Flexible Spending Accounts

Premium Only Plan (POP)

THREE GREAT WAYS TO OFFER EMPLOYEES DENTAL

Dentegra® Smile Club is included at no additional cost through the **Member Value Suite** and offers reduced fees for dental care services and a network of more than 20,000 providers.

MetLife MET100 and **MET185 DHMO** benefits are available for a low monthly payment and offer $5 office visits and no charge for oral exams, X-rays and two cleanings per year!

SmileSaver℠ 3000 and **1000 DHMO** benefits are available for a low monthly payment and offer FREE office visits, oral exams, X-rays and two cleanings per year!

Ameritas PPO benefits offer low deductibles that allow members to visit any dental provider they prefer, in- or out-of-network.

MetLife, SmileSaver and Ameritas can be added as voluntary plans with no minimum employee participation.

Included in the Member Value Suite

Plan Benefits	Dentegra Smile Club	MetLife Plan MET100	MetLife Plan MET185	SmileSaver Plan 3000	SmileSaver Plan 1000
Exams & Diagnostics	Coverage discounts equal 58% and are dental provider specific. Please see www.dentegrasmileclub.com and click on "Find a Dentist" for a list of dental providers.				
Office Visits		$5 Copay	$5 Copay	No Charge	No Charge
Initial Oral Exam		No Charge	No Charge	No Charge	No Charge
Periodic Oral Exam		No Charge	No Charge	No Charge	No Charge
Teeth Cleaning		No Charge	No Charge	No Charge	No Charge
X-Rays Bite-Wing (4 films)		No Charge	No Charge	No Charge	No Charge
Oral Surgery					
Removal of Uncomplicated Single Tooth		No Charge	No Charge	$10 Copay	No Charge
Removal of Impacted Tooth - partially bony		$40 Copay	$65 Copay	$50 Copay	No Charge
Removal of Impacted Tooth - completely bony		$75 Copay	$80 Copay	$65 Copay	No Charge
Restorative					
Cavities - Amalgam 1 Surface		No Charge	$10 Copay	$9 Copay	No Charge
Cavities - Amalgam 2 Surfaces		No Charge	$15 Copay	$14 Copay	No Charge
Endodontics					
Single Root Canal		$40 Copay	$80 Copay	$100 Copay	$40 Copay
Bi-Root Canal		$65 Copay	$115 Copay	$135 Copay	$65 Copay
Molar Root Canal		$95 Copay	$200 Copay	$185 Copay	$95 Copay
Periodontics					
Gingivectomy - Per Tooth		$38 Copay	$68 Copay	$30 Copay	No Charge
Periodontal Scaling & Root Planning (quadrant)		$25 Copay	$40 Copay	$26 Copay	$20 Copay
Crowns - Single Restoration					
Porcelain - Base Metal (posterior)		$175 Copay†	$260 Copay†	$225 Copay†	$175 Copay†
Full Cast Noble Metal		$100 Copay†	$185 Copay†	$115 Copay†	$60 Copay†
Orthodontics**					
Child (maximum age 18)		$1,450 Copay	$1,695 Copay	$1,600 Copay	$1,600 Copay
Adult		$1,450 Copay	$1,695 Copay	$1,950 Copay	$1,950 Copay
Prosthodontics					
Complete Upper or Lower Denture		$125 Copay	$210 Copay	$120 Copay	$70 Copay
Partial Upper or Lower Denture		$110 Copay	$240 Copay	$110 Copay	$50 Copay

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

(Continued page 34)

Note: Copays listed for plans MET100, MET185, 3000 and 1000 are for services performed by general dentists. Please consult the EOC/SOB for specialist copays and any additional fees that may apply to specific procedures.

† Cost of high noble metal (gold, etc.) may be charged extra when used. Not to exceed actual laboratory cost of metal.

** 24 month treatment

DENTAL

(Continued from page 33)

	Ameritas PPO 3000[5,6]		Ameritas PPO 3500[5,6]		Ameritas PPO 4000[5,6]		Ameritas PPO 5000[5,6]	
Plan Benefits	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Annual Maximum	$1,100	$700	$1,100[4]	$1,100[4]	$1,300[4]	$1,100[4]	$1,700[4]	$1,400[4]
Annual Deductible	$50 (Max 3x/Fam)	$100 (Max 3x/Fam)	$50 (Max 3x/Fam)	$50 (Max 3x/Fam)	$25 (Max 3x/Fam)	$75 (Max 3x/Fam)	$25 (Max 3x/Fam)	$75 (Max 3x/Fam)
Preventive Care	Ded. Waived	Ded. Waived	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies	Ded. Waived	Ded. Applies
Preventive	100%	80%	100%	100%	100%	80%	100%	80%
Basic	80%	80%	80%/90%/100%*	80%	80%/90%/100%*	80%	80%/90%/100%*	80%
Major (12 Month Wait)[1]	50%	50%	80%	50%	50%	50%	50%	50%
Endo/Perio[1]	50%	50%	80%	50%	80%	50%	80%	50%
"Fusion" Vision Reimbursement Annual Maximum	N/A		$100**		$100**		$100**	

Orthodontia[3]	Ameritas PPO 3000[5,6]		Ameritas PPO 3500[5,6]		Ameritas PPO 4000[5,6]		Ameritas PPO 5000[5,6]	
Maximum Age 18	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**	**In-Network**	**Out-of-Network†**
Orthodontia (12 Month Wait)[2]	Not Covered	Not Covered	50%	50%	50%	50%	50%	50%
Annual Maximum	Not Covered	Not Covered	None	None	None	None	None	None
Lifetime Maximum	Not Covered	Not Covered	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000

DENTAL REWARDS® BY AMERITAS

Members who visit the dentist and use only a portion of their annual maximum benefit in a year are rewarded with additional benefits for the following year. Based on the plan selected, members can earn additional money toward their next year's annual maximum benefit – if they use less than their Benefit Threshold listed below, they can increase their next year's coverage by $250 and earn an additional $100 to $150 if they visit a network provider. For more information on Dental Rewards, please visit www.ameritas.com. (Dental Rewards is a registered service mark of Ameritas Life Insurance Corp. and is used with permission.)

	PPO 3000[5,6]	PPO 3500[5,6]	PPO 4000[5,6]	PPO 5000[5,6]
Carry Over Amount	N/A	$250	$250	$250
PPO Bonus	N/A	$100	$100	$150
Benefit Threshold	N/A	$500	$500	$750
Maximum Carry Over Amount	N/A	$1,000	$1,000	$1,000

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* Submit one covered dental claim each year and your Basic procedures will advance to the 90% level the following year and to 100% on the third year.

** Annual maximum per calendar year to spend at any eye care provider. File claim with Ameritas Group for reimbursement.

† Plan 3000 and 3500 out-of-network claims are reimbursed at MAB. Plan 4000 and 5000 out-of-network claims are reimbursed at UCR.

1. 12 month waiting period applies. Waiting period will be waived for Groups with 10+ employees and 12 months continuous uninterrupted dental coverage on previous plan.
2. 12 month waiting period applies. Waiting period will be waived for Groups with 10+ employees and 12 months continuous uninterrupted orthodontia coverage on previous plan.
3. Orthodontia benefits are available to children only. Treatment must begin prior to their 19th birthday.
4. Annual maximum is a dental/vision combined benefit; you choose how to spend your maximum – it may be used toward dental and/or eye care expenses with maximum of $100 toward eye care expenses.
5. Please consult the applicable plan certificate for specific plan details.
6. Includes Maternity Benefit which provides an additional comprehensive evaluation and cleaning during pregnancy (See EOC for details).

Please refer to the Evidence of Coverage for more detailed information.

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(Continued from page 34)

AMERITAS EXTRAS*

Members enrolled on the PPO 4000 or PPO 5000 now have LASIK and Hearing Care Coverage benefits!

These benefits are not tied to a network so members can seek services from any LASIK or hearing care provider. The benefits can even be used in conjunction with discounts or specials offered by the provider.

The LASIK benefit makes it more affordable for members to obtain laser vision corrections and reduce their dependency on glasses or contacts.

The hearing benefit provides coverage for an annual hearing exam and helps cover the cost of hearing devices and maintenance.

LASIK Lifetime Benefit per Eye[1]	Benefit
Lifetime maximum per person[2]	$175 if used in year 1 $175 if used in year 2 $350 if you wait and use it in year 3

Annual Hearing Exam Benefit[1]	$75
Hearing Aid Benefit per Ear[3, 4]	$75
Hearing Aid Maintenance	$100 is used in year 1 $300 if used in year 2 $400 if used in year 3
Batteries, service contracts, fittings, ear mold and repairs	$40

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* Lasik and Soundcare benefits are available to groups with 5+ enrolled Dental PPO members.

1. This is only a summary of benefits. Please consult Ameritas Certificate for complete coverage details.
2. The maximum is per eye and cannot be combined toward double coverage for a single eye
3. Once the hearing benefit is used, at any level, members become re-eligible for the benefit, at the top level, after five (5) years as long as there is not break in coverage. A reduced benefit is available after three (3) years if there is hearing deterioration the current aids can't correct, as long as there is no break in coverage.
4. Plan pays 50% of hearing aid cost up to the maximum benefit amount. The maximum is per ear and cannot be combined toward double coverage for single ear.

TWO VISION PROGRAMS, INCLUDING ONE AT NO ADDITIONAL COST

Vision discounts available through EyeMed Vision Care (**Vision One Eyecare Discount Program**) provided by Ameritas is included at no additional cost through the Member Value Suite and offers all CaliforniaChoice® members discounts on frames, lenses, and eye examinations at any America's Best, EyeMart Express, Target optical centers, LensCrafters, and participating Pearle Vision locations.

The Voluntary Vision Program offers comprehensive vision insurance benefits and prescription eyewear through a large network of doctors. Members get eye exams every twelve months with a $10 copay.

Included in the Member Value Suite

Vision One Eyecare Discount Program	Voluntary Vision – EyeMed Provided by Ameritas	Voluntary Vision – VSP Provided by Ameritas
All CaliforniaChoice medical members and their dependents are eligible for immediate savings.	All CaliforniaChoice members and their dependents may enroll in one of the voluntary vision plans if their employer elects to offer this coverage.	
Frames and Lens Savings: Up to 40% savings on frames, 40% on bifocals, and 15% on non-disposable contact lenses.	**Comprehensive Benefits:** members access quality vision care and prescription eyewear through a vast network of doctors. Out-of-network coverage is also available.	**Comprehensive Services:** VSP offers members access to the nation's largest network of eye care professionals. Out-of-network coverage is also available.
Exam Discounts: Many participating licensed independent Doctors of Optometry offer $5 discounts off their regular exam fees and $10 off their regular contact lens exam fees.	**Low Fee Exams:** In-network benefits offer a low copay of only $10 for an eye exam.	
Easy to Use: To find the provider closest to you, visit www.eyemedvisioncare.com and click on EyeMed Vision Care Providers for EyeMed and visit www.vsp.com/ and click on Find a Doctor for VSP.		

Continued from previous page

Included in the Member Value Suite

	Vision One Eyecare Discount Program	Voluntary Vision–EyeMed Provided by Ameritas		Voluntary Vision–VSP Provided by Ameritas	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Examinations	**Participating Providers** $5 off routine exam $10 off contact lenses exam	$10 copay (1 per 12 months)	Up to $20 reimbursement	$10 copay (1 per 12 months)	Up to $45 reimbursement
Frames Any frame available at provider location	**Employee Cost** Up to 40% off of retail price	**In-Network Copay** Covered in Full up to $100 retail value (1 per 12 months)	**Out-of-Network Reimbursement** Up to $30 reimbursement up to $100 retail value (1 per 12 months)	**In-Network Copay** Covered in full up to $180 retail Value (1 per 12 months)	**Out-of-Network Reimbursement** Up to $70 reimbursement
Lenses Single Vision Bifocal Trifocal Standard-progressive (No line bifocals; Amount added to bifocal cost)	 $50 $70 $105 $65	(1 per 12 months) $10 $10 $10 $75	 Up to $20 reimbursement Up to $30 reimbursement Up to $40 reimbursement Up to $30 reimbursement	(1 per 12 months) $10 $10 $10 $55	 Up to $30 reimbursement Up to $50 reimbursement Up to $65 reimbursement Up to $50 reimbursement
Lens Options Polycarbonate Scratch-resistant coating Ultraviolet coating Solid or gradient tint Photochromic Anti-reflective coating	 $40 $15 $15 $15 20% off retail price $45	(in addition to lens copayment above) $40 $15 $15 $15 20% off of retail price $45	 Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	(in addition to lens copayment above) Covered in full for dependent children, $33 adults $17 - $33 $16 $15 - $17 $31 - $82 $43 - $85	 Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Contact Lenses	Save 15% off non-disposable contacts at nationwide locations and use the Vision One Contact Lens Replacement program for additional savings and convenience.	$10 (1 purchase per 12 months, in lieu of lenses and frames up to $100 retail value) **Contact Lens Fitting** Standard - Covered in Full Premium - 90% of charges (less $40 allowance)[1]	$50 reimbursement (1 purchase per 12 months, in lieu of lenses and frames up to $100 retail value) **Contact Lens Fitting** Standard - $40 reimbursement Premium - $40 reimbursement	$10 Copay (1 purchase per 12 months, in lieu of lenses and frames up to $180 retail value) **Contact Lens Fitting** Covered in full after member cost of up to $60	Up to $105 reimbursement (1 purchase per 12 months, in lieu of lenses and frames up to $180 retail value) **Contact Lens Fitting** 15% discount

Co-payments listed are Member responsibility.

1. Coinsurance is member responsibility.

CHIROPRACTIC AND ACUPUNCTURE

CHIROPRACTIC AND ACUPUNCTURE

Landmark Healthplan's Chiropractic and Acupuncture benefits are available for a low monthly premium and include affordable member copays.

	Plan 1 + Chiro Only	Plan 2 + Chiro and Acupuncture
Office Visits Includes examinations, manipulation, conjunctive physiotherapy, and X-Rays	$15 Copay Per Visit Maximum - 20 Visits Per Plan Year	$15 Copay Per Visit Maximum - 20 Visits Per Plan Year (combined between Chiropractic and Acupuncture)
Acupuncture Treatment **Herbal Therapies***	Not Covered Not Covered	$15 Copay Per Visit $5 Copay Per Bottle (Maximum $500 per plan year)
Chiropractic Discounts Office Visits Examinations Adjustments Diagnostic Procedures & X-Rays Chiropractic Medical Appliances	In addition to the 20 office visits for $15 each, members will receive additional discounts through Landmark Healthplan's network of providers. These additional discounts are listed below, but are not limited to: minimum 25% discount for professional services	
Acupuncture Discounts Office Visits Examinations All Acupuncture Procedures (Includes electro-acupuncture, moxibustion, acupressure and cupping)	Not covered	Minimum 20% Discount for Professional Services

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

* Herbal Therapies are for oral ingestion or external application of naturally occurring botanical, animal, or mineral substances to support normal structure and function of the human body according to the principles of traditional Oriental medicine.

\+ Coverage is available for residents in California only.

LIFE INSURANCE AND AD&D BY ASSURITY LIFE INSURANCE COMPANY

Assurity Life allows your employees to provide for their loved ones in the event of death. Accidental Death & Dismemberment (AD&D) benefits are also provided through this policy.

Coverage begins at a $10,000 minimum life insurance amount at initial enrollment ($5,000 minimum life insurance amount after initial enrollment) and increases based on the number of employees who enroll in the program.

Through the Living Benefits Provision, this benefit also provides a partial payment of the life insurance amount to policyholders who become terminally ill.

Policyholders may also exercise a Conversion Privilege – if you leave your job, are terminated, or otherwise end coverage – to convert your life policy to a private policy within 31 days of termination with no medical exam required.

Initial Enrollment

Employee Participation	Guaranteed Issue Maximum
1-10	$25,000
11-25	$50,000
26-50	$75,000
51-100	$100,000

After Initial Enrollment

Employee Participation	Guaranteed Issue Maximum Up to:
1-5	$5,000
6-10	$10,000
11-25	$25,000
26-100	$50,000

Note: A suicide exclusion applies to life insurance amount during the first two years and to AD&D at any time.

HEARING PROGRAM
PRESCRIPTION DISCOUNTS

HEARING PROGRAM

Included in the Member Value Suite

CaliforniaChoice® offers **EPIC Hearing Service Plan** (HSP) to you and your employees at no additional monthly cost through the **Member Value Suite**.

Savings On:

- Hearing tests
- Hearing aids
- Hearing aid batteries
- Ear protection
- Swim plugs
- Musician ear plugs
- Assistive listening devices
- Hearing aid cleaning supplies & accessories
- TV ears (amplifies & clarifies television)
- Telephone amplification
- Altering and signaling devices

Did you know?

- Hearing loss is the 3rd most chronic ailment in the nation
- 48 million Americans have some sort of hearing loss
- 65% with hearing loss are working adults 45 - 64

Advantages of EPIC HSP:

- Save up to 50% on brand name hearing aids
- All levels of technology and hearing aid styles
- Reduced costs on services & products
- National network of local ear physicians and audiologists
- Toll free telephone support
- Flexible payment plan
- No administrative forms or paperwork to fill out

PRESCRIPTION DISCOUNTS

Included in the Member Value Suite

The **California Rx Card® Program** is available to all CaliforniaChoice members and offers prescription discounts up to 75%. There are no restrictions or participation guidelines to join.

Employees can download their card at **www.californiarxcard.com** to get discounts at participating pharmacies including:

- CVS
- Walgreens
- Vons
- Kmart
- Ralphs
- Sav-On Pharmacy
- Many other chain and independent pharmacies

EMPLOYEE DISCOUNTS
FITNESS AND WELLNESS DISCOUNTS

FREE EMPLOYEE DISCOUNTS FROM CAL PERKS

Included in the Member Value Suite

You and your employees will have access to **Cal Perks**, a free membership program providing great discounts on entertainment and attractions throughout California including:

- Theme parks
- Water parks
- Sporting events
- Museums
- Movies
- Golf
- Flowers
- Dry cleaning
- Hotels
- Warehouse store memberships
- Plus a whole lot more!

Log-in to calchoice.com for Current Discounts Available

FITNESS AND WELLNESS DISCOUNTS

Included in the Member Value Suite

The ChooseHealthy® program reflects CaliforniaChoice's® commitment to helping members stay healthy today – and for the long term. You can enjoy access to exclusive deals on fitness and wellness brands.

Shop and save on a variety of health and wellness products at negotiated rates:

- Get discounts of up to 57% on top brands including Fitbit, Garmin, Vitamix, and more
- Access online health classes and articles offered at no extra cost
- Enroll in the Active&Fit Direct™ program and choose from 10,000 fitness centers nationwide for $25 a month
  - Take advantage of online fitness tracking
  - Search easily online for a location convenient to work or home
  - Use a guest pass to find a facility that's right for you – and enjoy the freedom to switch centers anytime, based on your individual needs

HR SUPPORT
PAYROLL SERVICES

ONLINE HR SUPPORT CENTER

Included in the Business Solutions Suite

You have 24-hour access to critical state and federal employment laws and a database of more than 2,500 questions and answers to common human resource issues. You can also download and customize Employee Handbooks, forms, and job descriptions at no additional cost as a part of the **Business Solutions Suite**.

The HR Support Center Offers You:

- Access to a document library with copies of Employee Handbooks, Company Policies, Job Descriptions, and HR Forms
- The latest employment laws as well as details about laws that have been updated
- Summaries of both state and federal laws that affect employers
- A database of questions and answers on subjects ranging from benefits and compensation, to labor relations and recruitment
- A glossary of commonly used HR terms and definitions
- A compilation of tools and information specific to Leave of Absence, Hiring, Performance Management, and Termination
- Great pricing on HR posters, books, and training videos
- A subscription to the monthly e-newsletter *HR Advisor* that is designed to keep you aware of the most current HR best practices and legal changes
- Articles written by HR Professionals with tips, information, and best practices to help you better manage your business and employees

PAYROLL SERVICES POWERED BY HEARTLAND PAYROLL SOLUTIONS, INC.

Simplify your business by integrating **Heartland Payroll Solutions, Inc.** with your CaliforniaChoice® benefits at no additional cost. Our Payroll Services work directly with your CaliforniaChoice account, so any payroll changes you make are directly communicated in real time. This allows you to:

- Reduce overall administration
- Avoid overpayments of premiums on terminated employees
- Avoid missed coverage windows for new hires

Payroll Services Include:

- **Direct Deposit**
  A secure, convenient, and cost-effective alternative to paper checks
- **Free Employee Payroll Portal (Intranet)**
  Free Intranet provides employees with a secure platform to view and print pay stubs and W2s, update information, and post important company documents and procedures
- **Outstanding Service**
  A dedicated payroll specialist will be assigned to you
- **Customized Payroll Reporting**
  You'll receive a Payroll Summary, Payroll Register, Payroll Tax Report, and Employee Pay Stub with every payroll – and you can select a variety of standard payroll reports or create custom reports exactly the way you want
- **Eliminate Liability**
  Year-to-date conversion back to January. Taxes, quarterly, and annual reports. Guaranteed accuracy of timely deposit and filings two-hour call back guarantee or your payroll is free!

COBRA BILLING
FSAs AND POPs

CAL-COBRA AND FEDERAL COBRA BILLING

INCLUDED IN THE Business Solutions Suite

With CaliforniaChoice®, COBRA-related activities are included at no additional cost and employers have support in the following areas:

- COBRA participant invoicing
- Premium collection and remittance
- Tracking payment time frames
- Processing eligibility changes for non-payment scenarios

Cal-COBRA applies to employers with 1-19 employees;
Federal COBRA applies to employers with 20 or more employees.

FLEXIBLE SPENDING ACCOUNT (FSA)

INCLUDED IN THE Business Solutions Suite

With an FSA, your employees set aside a portion of their salary, on a pre-tax basis, to pay for eligible FSA expenses. This process means they pay less in taxes while lowering your FICA contributions so your organization saves, too.

Available to groups with 15 or more employees.

Eligible Healthcare Expenses Include:

- Medical Expenses: copays, coinsurance, and deductibles
- Dental Expenses: exams, cleanings, x-rays, and braces
- Vision Expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Prescription drugs and insulin
- Professional Services: Chiropractic and Acupuncture
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.
- Hundreds of additional expenses

SECTION 125 PREMIUM ONLY PLAN (POP)

INCLUDED IN THE Business Solutions Suite

Premium Only Plans allow your employees to pay their share of health care premiums (health and dental) with pre-tax dollars, allowing them to take home more money. And when your taxable payroll decreases, you save money by reducing FICA and Workers' Compensation expenses.

ADDITIONAL FOOTNOTES

Groups Beginning 4/1/22

PlatinumHMO

(Footnotes from page 10-13)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

‡ This plan includes certain Infertility benefits; please see the CaliforniaChoice® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

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

1. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
2. Certain services available in Mexico, have a separate OOPM, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both OOPMs.
3. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
4. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
5. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
6. 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.
7. Specialty medication is tiered based on their cost efficiency and effectiveness. To see if there is a Specialty equivalent medication in this tier, please visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists.
8. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.
9. 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. 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.
11. 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.
12. 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.
13. 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.
14. 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.
15. Medical emergency only.
16. 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.

GoldHMO

(Footnotes continued from page 19)

12. 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.
13. 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.
14. 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.
15. 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.
16. 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.
17. 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.
18. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
19. 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.
20. 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.
21. 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.
22. Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of-pocket maximums.
23. $1,600 Self only enrollment, $2,800 for any one member within a Family enrollment. $3,200 for an entire Family. Does not apply to preventive care.

ADDITIONAL FOOTNOTES

Groups Beginning 4/1/22

GoldPPO

(Footnotes from page 20 and 21)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

‡ This plan includes Infertility benefits; please see the CaliforniaChoice® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

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

1. 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.
2. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
3. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
4. Amount listed is maximum paid by Anthem.
5. Medical emergency only.
6. 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.

SilverHMO

(Footnotes continued from page 25)

13. 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.
14. 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.
15. 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.
16. 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.
17. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
18. $2,500 Self only enrollment, $2,800 for any one member within a Family enrollment. $5,000 for an entire family. Does not apply to preventive care.
19. 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.
20. 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.
21. Maximum member responsibility.
22. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
23. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
24. Medical emergency only.
25. 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.
26. 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.

ADDITIONAL FOOTNOTES

Groups Beginning 4/1/22

SilverPPO & EPO

(Footnotes from page 26 and 27)

Co-insurances listed are the Plan responsibility and co-payments listed are Member responsibility.

† A Health Savings Account (HSA)-qualified health plan is a high-deductible health plan that often offers lower monthly premiums as compared to non-HSA-compatible health plans. These HSA-qualified plans are typically used in combination with an HSA that allows an individual to pay for qualified medical expenses with tax-advantaged dollars.

‡ This plan includes certain Infertility benefits; please see the CaliforniaChoice® Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits.

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

1. 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.
2. Family Deductible: For any given Member, cost share applies either after he/she meets their individual Deductible, or after the entire family Deductible is met. The family Deductible can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Deductible toward the family Deductible.
3. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
4. Amount listed is maximum paid by Anthem.
5. Medical emergency only.
6. Maximum member responsibility.
7. Deductible applies depending on who is covered under the plan at the time service is rendered - Subscriber only: $2,000 individual deductible; or Subscriber and Family coverage: $2,8 00 individual and $4,000 family deductible. For family deductible, for any given member, cost share applies either after he/she meets the per member deductible, or after the entire family deductible is met. The per family deductible can be met by any combination of amounts from any member, however no one member may contribute any more than his/her per member deductible toward the family deductible.
8. 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.
9. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
10. $2,500 Self only enrollment, $2,800 for any one member within a Family enrollment. $5,600 for an entire Family. Does not apply to preventive care.
11. Deductible is waived for drugs on the PreventiveRx Plus drug list.

BronzeHMO, PPO & EPO

(Footnotes continued from page 31)

21. Medical emergency only.
22. 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.
23. 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.
24. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual.
25. 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.
26. 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.
27. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
28. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
29. Amount listed is maximum paid by Anthem.
30. 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.
31. Deductible is waived for drugs on the PreventiveRx Plus drug list.

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