EMPLOYER

PROGRAM GUIDE

CaliforniaChoice®
Your Health. Your Choice.®

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 7.1.2025



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*and **CaliforniaChoice**® Member*

A GIRL MOM
A GO GETTER
OPTIMISTIC

I AM CALIFORNIA DIFFERENT®

Anthem
health net
KAISER PERMANENTE®
SHARP Health Plan
Sutter Health Plan
United Healthcare
westernhealth 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

Born and raised in California, CaliforniaChoice® celebrates the fact that each of your employees is different—with their own unique needs. We embrace those differences because we, too, are different. Our program gives your employees the freedom to choose the health plan they want. It acknowledges that **your health** should be **your choice**.

We're not your traditional employee benefits program. With CaliforniaChoice, you have the freedom to offer it all while staying focused on what's important to you - your business.

CaliforniaChoice®
Your Health. Your Choice.®

A California Different® way to do health care.



Program Overview

Everything you and your employees want in a benefits program:

- Seven 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



Program Overview *(continued)*

California Different® way to do health care.

7 Seven Health Plans in One

Anthem · health net · KAISER PERMANENTE · SHARP Health Plan · Sutter Health Plan · United Healthcare · westernhealth ADVANTAGE

With CaliforniaChoice®, **each employee** can choose **any one of seven 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.

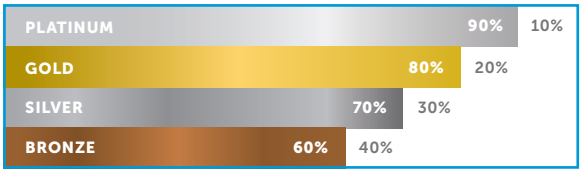
Program Overview *(continued)*

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.

METAL TIERS: (% Paid by Health Plan / Employee)



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.

Program Overview *(continued)*

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	
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	
PET INSURANCE	Discounted pet insurance options from two leading providers – **MetLife** and **Spot**. Keep your pets safe and healthy while avoiding expensive vet bills.
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 $28/month.



Program Overview *(continued)*

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

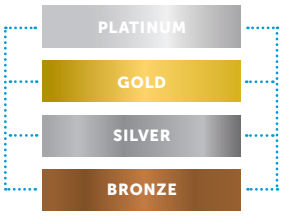
Total Choice – Offers employees access to the health plans and benefits available in all **four tiers**.

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**.

TOTAL CHOICE



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

- Bronze, Silver, Gold, Platinum

TRIPLE CHOICE



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

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

DOUBLE CHOICE



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

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

SINGLE CHOICE



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.

Platinum HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO A ‡	HMO B ‡	HMO C
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	Vivity	WholeCare
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$30 Copay
Hospital Services - In-Patient	$300 Copay per day – 3 days max per admit	$250 Copay per day – 4 days max per admit	$600 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$150 Copay	$250 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $5 Copay / Level 2 $15 Copay [11] Level 1 $20 Copay / Level 2 $30 Copay [11]	Level 1 $5 Copay / Level 2 $15 Copay [11] Level 1 $25 Copay / Level 2 $35 Copay [11]	$5 Copay [3, 4] $30 Copay [3, 4]
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [6]	$3,350 / $6,700 [6]	$2,700 / $5,400
Out-Patient Surgical Facility	$250 Copay	$150 Copay	$500 Copay
Ambulance (per trip)	$150 Copay [15]	$150 Copay [15]	$250 Copay

Medical Benefits	HMO E	HMO F	HMO G
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Full	WholeCare	Salud HMO y Mas
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$30 Copay	100%	100%
Hospital Services - In-Patient	$600 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	$275 Copay	$275 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay [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	$2,700 / $5,400	$3,850 / $7,700	$3,850 / $7,700 [2]
Out-Patient Surgical Facility	$500 Copay	$500 Copay	$500 Copay
Ambulance (per trip)	$250 Copay	$275 Copay	$275 Copay

(Footnotes on page 48)

Platinum HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO H	HMO I	HMO J
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Full	SmartCare	SmartCare
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	100%	100%	$30 Copay
Hospital Services - In-Patient	$500 Copay per day – 4 days max	$500 Copay per day - 4 days max	$600 Copay per day - 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$275 Copay	$250 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	100% [3, 4] $30 Copay [3, 4]	100% [3, 4] $30 Copay [3, 4]	$5 Copay [3, 4] $30 Copay [3, 4]
Out-of-Pocket Max Ind/Fam	$3,850 / $7,700	$3,850 / $7,700	$2,700 / $5,400
Out-Patient Surgical Facility	$500 Copay	$500 Copay	$500 Copay
Ambulance (per trip)	$275 Copay	$275 Copay	$275 Copay

Medical Benefits	HMO A	HMO B	HMO C
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	$250/ $500 [16] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$10 Copay	$20 Copay	$30 Copay (ded waived)
Hospital Services - In-Patient	$500 Copay per admit	$250 Copay per day – 5 days max	$500 Copay per admit
In-Patient Physician Fees	100%	100%	100% (ded waived)
Emergency Room (copay waived if admitted)	$200 Copay	$150 Copay	$250 Copay (ded waived)
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay $15 Copay	$5 Copay $20 Copay	$10 Copay (ded waived) $20 Copay (ded waived)
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000 [14]	$4,500 / $9,000 [14]	$3,000 / $6,000 [14]
Out-Patient Surgical Facility	$300 Copay per procedure	$125 Copay per procedure	$300 Copay per procedure (ded waived)
Ambulance (per trip)	$150 Copay	$150 Copay	$150 Copay (ded waived)

(Footnotes on page 48)

Platinum HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO A	HMO B	HMO C
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sharp Health Plan
Network Name	Premier	Performance	Premier
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$15 Copay	$15 Copay	$10 Copay
Hospital Services - In-Patient	$400 Copay	85%	$350 Copay per day – 5 days max
In-Patient Physician Fees	100%	85%	100%
Emergency Room (copay waived if admitted)	$150 Copay	85%	$200 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay $25 Copay	$10 Copay $25 Copay	$10 Copay $25 Copay
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000 [5]	$3,800 / $7,600 [5]	$4,000 / $8,000 [5]
Out-Patient Surgical Facility	80%	85%	80%
Ambulance (per trip)	$150 Copay	85%	$200 Copay

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

(Footnotes on page 48)

Platinum HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO B	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)	$20 Copay	$25 Copay	$25 Copay
Hospital Services - In-Patient	$300 Copay per day – 3 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)	$250 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 $20 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 $30 Copay / Tier 2 Specialty $150 Copay[7]
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000[8]	$4,000 / $8,000[8]	$3,000 / $6,000[8]
Out-Patient Surgical Facility	$200 Copay	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)	$25 Copay	$25 Copay	$25 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 $30 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 $30 Copay / Tier 2 Specialty $150 Copay[7]
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000[8]	$4,000 / $8,000[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 48)

Platinum HMO

Groups Beginning 7.1.2025

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)	$25 Copay	$25 Copay	$25 Copay
Hospital Services - In-Patient	90%	90%	90%
In-Patient Physician Fees	90%	90%	90%
Emergency Room (copay waived if admitted)	$400 Copay	$400 Copay	$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 $30 Copay / Tier 2 Specialty $150 Copay [7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [7] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [7] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [7]
Out-of-Pocket Max Ind/Fam	$3,500 / $7,000 [8]	$3,500 / $7,000 [8]	$3,500 / $7,000 [8]
Out-Patient Surgical Facility	90%	90%	90%
Ambulance (per trip)	$100 Copay	$100 Copay	$100 Copay

Medical Benefits	HMO M	HMO N	HMO A
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Harmony	Alliance	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$25 Copay
Hospital Services - In-Patient	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max per admit	$250 Copay per day – Days 1-5
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [7] Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [7]	Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [7] Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [7]	$10 Copay $30 Copay [13]
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [8]	$2,500 / $5,000 [8]	$4,000 / $8,000 [1]
Out-Patient Surgical Facility	$200 Copay	$200 Copay	$100 Copay
Ambulance (per trip)	$100 Copay	$100 Copay	100%

(Footnotes on page 48)

Platinum HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Dr. Office Visits (PCP)	$20 Copay	$20 Copay
Hospital Services - In-Patient	$250 Copay per day – Days 1-5	100%
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	$150 Copay	$150 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$5 Copay $20 Copay [13]	$5 Copay $30 Copay [13]
Out-of-Pocket Max Ind/Fam	$4,500 / $9,000 [1]	$5,500 / $11,000 [1]
Out-Patient Surgical Facility	$100 Copay	$150 Copay
Ambulance (per trip)	$150 Copay	100%

(Footnotes on page 48)

Platinum PPO

Groups Beginning 7.1.2025

Medical Benefits	PPO A ‡		PPO B	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Prudent Buyer – Small Group	
Metal Tier	**Platinum**		**Platinum**	
	In-Network	Out-of-Network [6]	In-Network	Out-of-Network [6]
Calendar Year Deductible*	None	$2,000 / $4,000 [2] (applies to Max OOP)	None	$2,000 / $4,000 [2] (applies to Max OOP)
Dr. Office Visits (PCP)	$10 Copay	50%	$10 Copay	50%
Hospital Services - In-Patient	90%	50% (up to $650 per day) [4]	90%	50% (up to $650 per day) [4]
In-Patient Physician Fees	90%	50%	90%	50%
Emergency Room (copay waived if admitted)	$500 Copay – 90%	$500 Copay – 90%	$500 Copay – 90%	$500 Copay – 90%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $5 Copay / Level 2 $15 Copay [1] Level 1 $15 Copay / Level 2 $25 Copay [1]	Not Covered Not Covered	Level 1 $5 Copay / Level 2 $15 Copay [1] Level 1 $15 Copay / Level 2 $25 Copay [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$8,000 / $16,000 [3]	$16,000 / $32,000 [3]	$5,000 / $10,000 [3]	$10,000 / $20,000 [3]
Out-Patient Surgical Facility	$200 Copay per admit – 90%	50% (up to $380 per admit) [4]	$200 Copay per admit – 90%	50% (up to $380 per admit) [4]
Ambulance (per trip)	90% [5]	90% [5]	90% [5]	90% [5]

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/Public/Forms) 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.

Gold HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO A ‡	HMO B ‡	HMO C ‡
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Network Name	Select HMO	CaliforniaCare HMO	Priority Select HMO
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$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
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$325 Copay	$325 Copay	$325 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]
Out-of-Pocket Max Ind/Fam	$7,250 / $14,500 [15]	$7,250 / $14,500 [15]	$7,250 / $14,500 [15]
Out-Patient Surgical Facility	$500 Copay	$500 Copay	$500 Copay
Ambulance (per trip)	$150 Copay [3]	$150 Copay [3]	$150 Copay [3]

Medical Benefits	HMO A	HMO B	HMO C
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	WholeCare	WholeCare
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$30 Copay	$40 Copay	$35 Copay
Hospital Services - In-Patient	$750 Copay per day – 4 days max	$750 Copay per day – 5 days max	$750 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$325 Copay	$350 Copay	$325 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$20 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	$7,250 / $14,500	$7,500 / $15,000	$7,350 / $14,700
Out-Patient Surgical Facility	$900 Copay	$1,200 Copay	$1,200 Copay
Ambulance (per trip)	$325 Copay	$350 Copay	$325 Copay

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Gold HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO D	HMO E	HMO G
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	Salud HMO y Mas	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$35 Copay	$35 Copay	$30 Copay
Hospital Services - In-Patient	$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%
Emergency Room (copay waived if admitted)	$325 Copay	$325 Copay	$325 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay[2, 4] $50 Copay[2, 4]	$15 Copay[2, 4] $50 Copay[2, 4]	$20 Copay[2, 4] $50 Copay[2, 4]
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700[22]	$7,350 / $14,700	$7,250 / $14,500
Out-Patient Surgical Facility	$1,200 Copay	$1,200 Copay	$900 Copay
Ambulance (per trip)	$325 Copay	$325 Copay	$325 Copay

Medical Benefits	HMO H	HMO I	HMO B
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	SmartCare	SmartCare	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$250 / $500[6] (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay	$40 Copay	$35 Copay (ded waived)
Hospital Services - In-Patient	$750 Copay per day – 4 days max	$750 Copay per day – 5 days max	$600 Copay per day – 5 days max
In-Patient Physician Fees	100%	100%	100% (ded waived)
Emergency Room (copay waived if admitted)	$325 Copay	$350 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)
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700	$7,500 / $15,000	$7,800 / $15,600[7]
Out-Patient Surgical Facility	$1,200 Copay	$1,200 Copay	$335 Copay per procedure
Ambulance (per trip)	$325 Copay	$350 Copay	$250 Copay

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Gold HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO C	HMO D	HMO E† HSA Qualified
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$1,000 / $2,000 [6] (applies to Max OOP)	$1,750 / $3,300 / $3,500 [6, 13] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay (ded waived)	$40 Copay (ded waived)	85%
Hospital Services - In-Patient	$600 Copay per day – 5 days max	$600 Copay per day – 5 days max	85%
In-Patient Physician Fees	100% (ded waived)	100% (ded waived)	85%
Emergency Room (copay waived if admitted)	$350 Copay (ded waived)	$350 Copay (ded waived)	85%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay (ded waived) $250 / $500 Ded - $50 Copay	$20 Copay (ded waived) $250 / $500 Ded - $50 Copay	$15 Copay (combined Med/Rx ded) $45 Copay (combined Med/Rx ded)
Out-of-Pocket Max Ind/Fam	$7,700 / $15,400 [7]	$8,200 / $16,400 [7]	$4,000 / $8,000 [7]
Out-Patient Surgical Facility	$320 Copay per procedure (ded waived)	$350 Copay per procedure (ded waived)	85%
Ambulance (per trip)	$250 Copay (ded waived)	$350 Copay (ded waived)	85%

Medical Benefits	HMO A	HMO B	HMO D
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sharp Health Plan
Network Name	Performance	Premier	Performance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$20 Copay	$40 Copay	$35 Copay
Hospital Services - In-Patient	70%	$600 Copay per day – 5 days max	$1,500 Copay
In-Patient Physician Fees	70%	100%	100%
Emergency Room (copay waived if admitted)	70%	$400 Copay	$300 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$16 Copay (ded waived) $250 / $500 Ded – $35 Copay	$16 Copay (ded waived) $500 / $1000 Ded – $45 Copay	$16 Copay $35 Copay
Out-of-Pocket Max Ind/Fam	$9,200 / $18,400 [5]	$9,200 / $18,400 [5]	$9,150 / $18,300 [5]
Out-Patient Surgical Facility	70%	75%	$600 Copay
Ambulance (per trip)	70%	$200 Copay	$200 Copay

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Gold HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO A	HMO B	HMO C† HSA Qualified
Participating Health Plans	Sutter Health Plan	Sutter Health Plan	Sutter Health Plan
Network Name	Sutter Health Plan	Sutter Health Plan	Sutter Health Plan
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,500 / $3,000 [10] (applies to Max OOP)	$250 / $500 [10] (applies to Max OOP)	$1,650 / $3,300 / $3,300 [10,18] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$30 Copay [11]	$35 Copay (ded waived) [11]	80% [11]
Hospital Services - In-Patient	80%	$600 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	80%	100% (ded waived)	80%
Emergency Room (copay waived if admitted)	$200 Copay	$250 Copay	80%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$15 Copay (overall ded waived) [12] $30 Copay (overall ded waived) [12]	$15 Copay (overall ded waived) [12] $40 Copay (overall ded waived) [12]	$15 Copay (combined Med/Rx ded) [12] $50 Copay (combined Med/Rx ded) [12]
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000 [14]	$7,800 / $15,600 [14]	$6,000 / $12,000 [14]
Out-Patient Surgical Facility	80%	$300 Copay	80%
Ambulance (per trip)	$200 Copay	$250 Copay	80%

Medical Benefits	HMO A	HMO B	HMO F
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	SignatureValue
Metal Tier	**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
Dr. Office Visits (PCP)	$35 Copay (ded waived)	$35 Copay (ded waived)	$35 Copay
Hospital Services - In-Patient	75%	75%	$700 Copay per day – 5 days max per admit
In-Patient Physician Fees	75% (ded waived)	75% (ded waived)	100%
Emergency Room (copay waived if admitted)	$500 Copay	$500 Copay	$500 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [8] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [8] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [8] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]
Out-of-Pocket Max Ind/Fam	$6,750 / $13,500 [9]	$6,750 / $13,500 [9]	$7,500 / $15,000 [9]
Out-Patient Surgical Facility	75%	75%	$500 Copay
Ambulance (per trip)	$100 Copay (ded waived)	$100 Copay (ded waived)	$100 Copay

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Gold HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO G	HMO H	HMO J
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	SignatureValue	Alliance
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	$500 / $1,000 [20] (applies to Max OOP)	$500 / $1,000 [20] (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay	$35 Copay (ded waived)	$35 Copay (ded waived)
Hospital Services - In-Patient	$700 Copay per day – 5 days max per admit	80%	80%
In-Patient Physician Fees	100%	80%	80%
Emergency Room (copay waived if admitted)	$500 Copay	$500 Copay	$500 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [8] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [8] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 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]	$7,500 / $15,000 [9]
Out-Patient Surgical Facility	$500 Copay	80%	80%
Ambulance (per trip)	$100 Copay	$100 Copay (ded waived)	$100 Copay (ded waived)

Medical Benefits	HMO L	HMO M	HMO N
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Harmony	Harmony	Harmony
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$1,250 / $2,500 [20] (applies to Max OOP)	None	$500 / $1,000 [20] (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay (ded waived)	$35 Copay	$35 Copay (ded waived)
Hospital Services - In-Patient	75%	$700 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	75% (ded waived)	100%	80%
Emergency Room (copay waived if admitted)	$500 Copay	$500 Copay	$500 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay (ded waived) [8] $100 / $200 Ded – Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [8] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 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	$6,750 / $13,500 [9]	$7,500 / $15,000 [9]	$7,500 / $15,000 [9]
Out-Patient Surgical Facility	75%	$500 Copay	80%
Ambulance (per trip)	$100 Copay (ded waived)	$100 Copay	$100 Copay (ded waived)

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Gold HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO O	HMO P	HMO Q
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Alliance	Harmony	SignatureValue
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	None
Dr. Office Visits (PCP)	$35 Copay	$35 Copay	$35 Copay
Hospital Services - In-Patient	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$400 Copay	$400 Copay	$400 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [8] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [8] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [8] 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]	$7,500 / $15,000 [9]
Out-Patient Surgical Facility	$400 Copay	$400 Copay	$400 Copay
Ambulance (per trip)	$100 Copay	$100 Copay	$100 Copay

Medical Benefits	HMO P	HMO Q	HMO B
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	Western Health Advantage
Network Name	Harmony	SignatureValue	Full
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	None	None	$250 / $500 [16, 17] (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay	$35 Copay	$35 Copay (ded waived)
Hospital Services - In-Patient	$600 Copay per day - 4 days max per admit	$600 Copay per day - 4 days max per admit	$600 Copay per day – Days 1-5 [16]
In-Patient Physician Fees	100%	100%	100% (ded waived)
Emergency Room (copay waived if admitted)	$400 Copay	$400 Copay	$250 Copay [16]
Rx Benefits - Generic Rx Benefits - Formulary Brand	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [8] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	Tier 1 Non-specialty $15 Copay / Tier 1 Specialty $15 Copay [8] Tier 2 Non-specialty $50 Copay / Tier 2 Specialty $150 Copay [8]	$15 Copay (overall ded waived) $40 Copay (overall ded waived) [19]
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000 [9]	$7,500 / $15,000 [9]	$7,800 / $15,600 [1, 17]
Out-Patient Surgical Facility	$400 Copay	$400 Copay	$300 Copay [16]
Ambulance (per trip)	$100 Copay	$100 Copay	$250 Copay [16]

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Gold HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO C	HMO D† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Gold**	**Gold**
Calendar Year Deductible*	$1,000 / $2,000[16, 17] (applies to Max OOP)	$2,600 / $3,300 / $5,200[16, 17, 18] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$40 Copay (ded waived)	100%[16]
Hospital Services - In-Patient	$500 Copay per day – Days 1-5[16]	100%[16]
In-Patient Physician Fees	100% (ded waived)	100%[16]
Emergency Room (copay waived if admitted)	$300 Copay[16]	100%[16]
Rx Benefits - Generic Rx Benefits - Formulary Brand	$10 Copay (ded waived) $500 / $1,000 Ded – $50 Copay[16, 19]	100% (combined Med/Rx ded)[16] $40 Copay (combined Med/Rx ded)[16, 19]
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600[1, 17]	$4,800 / $9,600[1, 17]
Out-Patient Surgical Facility	$500 Copay[16]	100%[16]
Ambulance (per trip)	100% (ded waived)	100%[16]

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Gold PPO

Groups Beginning 7.1.2025

Medical Benefits	PPO B ‡		PPO C ‡	
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*	$1,000 / $3,000 [2] (applies to Max OOP)	$2,000 / $4,000 [2] (applies to Max OOP)	$500 / $1,500 [2] (applies to Max OOP)	$2,000 / $4,000 [2] (applies to Max OOP)
Dr. Office Visits (PCP)	$25 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Hospital Services - In-Patient	75%	50% (up to $650 per day) [4]	80%	50% (up to $650 per day) [4]
In-Patient Physician Fees	75%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 75%	$250 Copay – 75%	$250 Copay – 80%	$250 Copay – 80%
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 (overall ded waived) [1] Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived) [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$7,800 / $15,600 [3]	$15,600 / $31,200 [3]	$7,700 / $15,400 [3]	$15,400 / $30,800 [3]
Out-Patient Surgical Facility	$250 Copay per admit – 75%	50% (up to $380 per admit) [4]	$250 Copay per admit – 80%	50% (up to $380 per admit) [4]
Ambulance (per trip)	75% [5]	75% [5]	80% [5]	80% [5]

Medical Benefits	PPO D ‡		PPO E ‡	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Prudent Buyer - Small Group	
Metal Tier	**Gold**		**Gold**	
	In-Network	Out-of-Network [6]	In-Network	Out-of-Network [6]
Calendar Year Deductible*	$1,500 / $3,000 [2] (applies to Max OOP)	$3,000 / $6,000 [2] (applies to Max OOP)	$500 / $1,500 [2] (applies to Max OOP)	$2,000 / $4,000 [2] (applies to Max OOP)
Dr. Office Visits (PCP)	$30 Copay (ded waived)	50%	$30 Copay (ded waived)	50%
Hospital Services - In-Patient	75%	50% (up to $650 per day) [4]	80%	50% (up to $650 per day) [4]
In-Patient Physician Fees	75%	50%	80%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 75%	$250 Copay – 75%	$250 Copay – 80%	$250 Copay – 80%
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 (overall ded waived) [1] Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived) [1]	Not Covered Not Covered
Out-of-Pocket Max Ind/Fam	$6,600 / $13,200 [3]	$13,200 / $26,400 [3]	$7,700 / $15,400 [3]	$15,400 / $30,800 [3]
Out-Patient Surgical Facility	$250 Copay per admit – 75%	50% (up to $380 per admit) [4]	$250 Copay per admit – 80%	50% (up to $380 per admit) [4]
Ambulance (per trip)	75% [5]	75% [5]	80% [5]	80% [5]

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Silver HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO A ‡	HMO B ‡	HMO A
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Health Net
Network Name	Select HMO	CaliforniaCare HMO	WholeCare
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,200 / $4,400 [25] (applies to Max OOP)	$2,200 / $4,400 [25] (applies to Max OOP)	None
Dr. Office Visits (PCP)	$60 Copay (ded waived)	$60 Copay (ded waived)	$55 Copay
Hospital Services - In-Patient	55%	55%	$750 Copay per day - 5 days max
In-Patient Physician Fees	100% (ded waived)	100% (ded waived)	100%
Emergency Room (copay waived if admitted)	$350 Copay – 55%	$350 Copay – 55%	50%
Rx Benefits - Generic Rx Benefits - Formulary Brand	Level 1 $10 Copay / Level 2 $20 Copay (ded waived) [8] $300 / $600 Ded – Level 1 $70 Copay / Level 2 $80 Copay [8]	Level 1 $10 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] $500 / $1,000 Ded – 50% (up to $250 per prescription [21]) [11, 23]
Out-of-Pocket Max Ind/Fam	$9,100 / $18,200 [15]	$9,100 / $18,200 [15]	$9,200 / $18,400
Out-Patient Surgical Facility	55%	55%	50%
Ambulance (per trip)	55% [24]	55% [24]	50%

Medical Benefits	HMO A	HMO B	HMO C
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente
Network Name	Full	Full	Full
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,300 / $4,600 [5] (applies to Max OOP)	$1,900 / $3,800 [5] (combined Med/Rx ded) (applies to Max OOP)	$2,500 / $5,000 [5] (applies to Max OOP)
Dr. Office Visits (PCP)	$65 Copay (ded waived)	$65 Copay (ded waived)	$55 Copay (ded waived)
Hospital Services - In-Patient	55%	55%	65%
In-Patient Physician Fees	55%	55%	65%
Emergency Room (copay waived if admitted)	55%	55%	65%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$20 Copay (ded waived) $500 / $1,000 Ded - $100 Copay	$20 Copay (ded waived) $100 Copay (ded waived)	$19 Copay (ded waived) $300 / $600 Ded – $85 Copay
Out-of-Pocket Max Ind/Fam	$8,750 / $17,500 [6]	$8,750 / $17,500 [6]	$8,750 / $17,500 [6]
Out-Patient Surgical Facility	55%	55%	65%
Ambulance (per trip)	55%	55%	65%

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Silver HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO D † HSA Qualified	HMO E	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,850 / $3,300 / $5,700 [5, 18] (combined Med/Rx ded) (applies to Max OOP)	$2,900 / $5,800 [5] (combined Med/Rx ded) (applies to Max OOP)	$2,600 / $5,200 [4] (applies to Max OOP)
Dr. Office Visits (PCP)	75%	$65 Copay (ded waived)	$45 Copay (ded waived)
Hospital Services - In-Patient	75%	55%	$975 Copay per day
In-Patient Physician Fees	75%	55%	100%
Emergency Room (copay waived if admitted)	75%	55%	$750 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	75% (combined Med/Rx ded) 75% (combined Med/Rx ded)	$20 Copay (ded waived) $100 Copay (combined Med/Rx ded)	$16 Copay (ded waived) $300 / $600 Ded – $120 Copay
Out-of-Pocket Max Ind/Fam	$7,500 / $15,000 [6]	$9,100 / $18,200 [6]	$9,200 / $18,400 [4, 22]
Out-Patient Surgical Facility	75%	55%	50%
Ambulance (per trip)	75%	55%	$400 Copay (ded waived)

Medical Benefits	HMO B	HMO C	HMO B
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sutter Health Plan
Network Name	Performance	Premier	Sutter Health Plan
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,600 / $5,200 [4] (applies to Max OOP)	$2,900 / $5,800 [4] (applies to Max OOP)	$2,500 / $5,000 [12] (applies to Max OOP)
Dr. Office Visits (PCP)	$40 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived) [13]
Hospital Services - In-Patient	60%	50%	65%
In-Patient Physician Fees	60%	50%	65% (ded waived)
Emergency Room (copay waived if admitted)	60%	50%	65%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$16 Copay (ded waived) $300 / $600 Ded – $110 Copay	$16 Copay (overall ded waived) $145 Copay (overall ded waived)	$19 Copay (ded waived) [14] $300 / $600 Ded – $85 Copay [14]
Out-of-Pocket Max Ind/Fam	$9,200 / $18,400 [4, 22]	$9,200 / $18,400 [4, 22]	$8,750 / $17,500 [16]
Out-Patient Surgical Facility	60%	50%	65%
Ambulance (per trip)	60% (ded waived)	50% (ded waived)	65%

(Footnotes on page 49-50)

Silver HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO C † (HSA Qualified)	HMO A	HMO E
Participating Health Plans	Sutter Health Plan	UnitedHealthcare	UnitedHealthcare
Network Name	Sutter Health Plan	SignatureValue	Alliance
Metal Tier	**Silver**	**Silver**	**Silver**
Calendar Year Deductible*	$2,800 / $3,300 / $5,600 [12, 17] (combined Med/Rx ded) (applies to Max OOP)	$2,400 / $4,800 [7] (applies to Max OOP)	$2,400 / $4,800 [7] (applies to Max OOP)
Dr. Office Visits (PCP)	$35 Copay [13]	$60 Copay (ded waived)	$60 Copay (ded waived)
Hospital Services - In-Patient	75%	60%	60%
In-Patient Physician Fees	75%	60% (ded waived)	60% (ded waived)
Emergency Room (copay waived if admitted)	75%	60%	60%
Rx Benefits - Generic Rx Benefits - Formulary Brand	$20 Copay (combined Med/Rx ded) [14] $40 Copay (combined Med/Rx ded) [14]	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	$7,200 / $14,400 [16]	$9,200 / $18,400 [10]	$9,200 / $18,400 [10]
Out-Patient Surgical Facility	75%	60%	60%
Ambulance (per trip)	75%	$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*	$2,400 / $4,800 [7] (applies to Max OOP)	$2,000 / $4,000 [7] (applies to Max OOP)	$2,300 / $4,600 [1, 19] (applies to Max OOP)
Dr. Office Visits (PCP)	$60 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 $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]	$20 Copay (ded waived) $500 / $1,000 Ded - 70% (up to $250 per prescription [21]) [1, 3, 20]
Out-of-Pocket Max Ind/Fam	$9,200 / $18,400 [10]	$9,200 / $18,400 [10]	$8,750 / $17,500 [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 49-50)

Silver HMO

Groups Beginning 7.1.2025

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*	$2,500 / $5,000 [1, 19] (applies to Max OOP)	$2,850 / $3,300 / $5,700 [1, 17, 19] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$55 Copay (ded waived)	75% [1, 3]
Hospital Services - In-Patient	65% [1, 3]	75% [1, 3]
In-Patient Physician Fees	65% (ded waived) [3]	75% [1, 3]
Emergency Room (copay waived if admitted)	65% [1, 3]	75% [1, 3]
Rx Benefits - Generic	$19 Copay (ded waived)	75% (up to $250 per 30 day supply [21]) (combined Med/Rx ded) [1, 3]
Rx Benefits - Formulary Brand	$300 / $600 Ded – $85 Copay [1, 20]	75% (up to $250 per 30 day supply [21]) (combined Med/Rx ded) [1, 3, 20]
Out-of-Pocket Max Ind/Fam	$8,750 / $17,500 [2, 19]	$7,500 / $15,000 [2, 19]
Out-Patient Surgical Facility	65% [1, 3]	75% [1, 3]
Ambulance (per trip)	65% [1, 3]	75% [1, 3]

(Footnotes on page 49-50)

Silver PPO

Groups Beginning 7.1.2025

Medical Benefits	PPO B ‡		PPO C ‡	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Select PPO		Prudent Buyer – Small Group	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [8]	In-Network	Out-of-Network [8]
Calendar Year Deductible*	$1,700 / $3,400 [2] (applies to Max OOP)	$3,400 / $6,800 [2] (applies to Max OOP)	$1,700 / $3,400 [2] (applies to Max OOP)	$3,400 / $6,800 [2] (applies to Max OOP)
Dr. Office Visits (PCP)	$50 Copay (ded waived)	50%	$50 Copay (ded waived)	50%
Hospital Services - In-Patient	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)	$300 Copay – 60%	$300 Copay – 60%	$300 Copay – 60%	$300 Copay – 60%
Rx Benefits - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [1]	Not Covered	Level 1 $15 Copay / Level 2 $20 Copay (ded waived) [1]	Not Covered
Rx Benefits - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [1]	Not Covered	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay [1]	Not Covered
Out-of-Pocket Max Ind/Fam	$9,100 / $18,200 [3]	$18,200 / $36,400 [3]	$9,100 / $18,200 [3]	$18,200 / $36,400 [3]
Out-Patient Surgical Facility	$250 Copay per admit – 60%	50% (up to $380 per admit) [4]	$250 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 D †, ‡ HSA Qualified		PPO E †, ‡ HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Silver**		**Silver**	
	In-Network	Out-of-Network [8]	In-Network	Out-of-Network [8]
Calendar Year Deductible*	$2,000 / $3,300 / $4,000 [2] (combined Med/Rx ded) (applies to Max OOP)	$4,000 / $6,600 / $8,000 [2] (combined Med/Rx ded) (applies to Max OOP)	$2,000 / $3,300 / $4,000 [2] (combined Med/Rx ded) (applies to Max OOP)	$4,000 / $6,600 / $8,000 [2] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	65%	50%	65%	50%
Hospital Services - In-Patient	65%	50% (up to $650 per day) [4]	65%	50% (up to $650 per day) [4]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%	65%	65%	65%
Rx Benefits - Generic	Level 1 $15 Copay / Level 2 $20 Copay (combined Med/Rx ded) [1,6]	Not Covered	Level 1 $15 Copay / Level 2 $20 Copay (combined Med/Rx ded) [1,6]	Not Covered
Rx Benefits - Formulary Brand	Level 1 $70 Copay / Level 2 $80 Copay (combined Med/Rx/ded) [1,6]	Not Covered	Level 1 $70 Copay / Level 2 $80 Copay (combined Med/Rx/ded) [1,6]	Not Covered
Out-of-Pocket Max Ind/Fam	$7,700 / $15,400 [3]	$15,400 / $30,800 [3]	$7,700 / $15,400 [3]	$15,400 / $30,800 [3]
Out-Patient Surgical Facility	$250 Copay per admit – 65%	50% (up to $380 per admit) [4]	$250 Copay per admit – 65%	50% (up to $380 per admit) [4]
Ambulance (per trip)	65% [5]	65% [5]	65% [5]	65% [5]

(Footnotes on page 50)

Bronze HMO

Groups Beginning 7.1.2025

Medical Benefits	HMO A	HMO C † HSA Qualified	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,800 / $11,600 [19] (applies to Max OOP)	$6,650 / $13,300 [19] (combined Med/Rx ded) (applies to Max OOP)	$7,600 / $15,200 [4] (applies to Max OOP)
Dr. Office Visits (PCP)	$60 Copay (ded waived)	100%	$55 Copay
Hospital Services - In-Patient	60%	100%	$1,500 Copay per day – 3 days max
In-Patient Physician Fees	60%	100%	100%
Emergency Room (copay waived if admitted)	60%	100%	$500 Copay
Rx Benefits - Generic Rx Benefits - Formulary Brand	$19 Copay (ded waived) $450 / $900 Ded – 60% (up to $500 per prescription [18])	100% (combined Med/Rx ded) 100% (combined Med/Rx ded)	$16 Copay (overall ded waived) $60 Copay (overall ded waived)
Out-of-Pocket Max Ind/Fam	$8,850 / $17,700 [5]	$6,650 / $13,300 [5]	$8,500 / $17,000 [4, 14]
Out-Patient Surgical Facility	60%	100%	60%
Ambulance (per trip)	60%	100%	$500 Copay

Medical Benefits	HMO B † HSA Qualified	HMO A	HMO B † HSA Qualified
Participating Health Plans	Sharp Health Plan	Sutter Health Plan	Sutter Health Plan
Network Name	Performance	Sutter Health Plan	Sutter Health Plan
Metal Tier	**Bronze**	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,200 / $12,400 [10] (combined Med/Rx ded) (applies to Max OOP)	$5,800 / $11,600 [11] (applies to Max OOP)	$6,650 / $13,300 [11] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	60%	$60 Copay (ded waived) [12]	100% [12]
Hospital Services - In-Patient	60%	60%	100%
In-Patient Physician Fees	60%	60%	100%
Emergency Room (copay waived if admitted)	60%	60%	100%
Rx Benefits - Generic	60% (up to $500 per prescription [18]) (combined Med/Rx ded)	$19 Copay (ded waived) [14]	100% (combined Med/Rx ded) [14]
Rx Benefits - Formulary Brand	60% (up to $500 per prescription [18]) (combined Med/Rx ded)	$450 / $900 Ded – 60% (up to $500 per prescription [18]) [14]	100% (combined Med/Rx ded) [14]
Out-of-Pocket Max Ind/Fam	$7,100 / $14,200 [10, 14]	$8,850 / $17,700 [16]	$6,650 / $13,300 [16]
Out-Patient Surgical Facility	60%	60%	100%
Ambulance (per trip)	60%	60%	100%

(Footnotes on page 51)

Bronze HMO

Groups Beginning 7.1.2025

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*	$5,800 / $11,600 [1, 8] (applies to Max OOP)	$6,650 / $13,300 [1, 8] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	$60 Copay (ded waived)	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	$19 Copay (ded waived) $450 / $900 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	$8,850 / $17,700 [2, 8]	$6,650 / $13,300 [2, 8]
Out-Patient Surgical Facility	60% [1, 3]	100% [1]
Ambulance (per trip)	60% [1, 3]	100% [1]

(Footnotes on page 51)

Bronze PPO

Groups Beginning 7.1.2025

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 [15] (combined Med/Rx ded) (applies to Max OOP)	$12,500 / $25,000 [15] (combined Med/Rx ded) (applies to Max OOP)	$6,250 / $12,500 [15] (combined Med/Rx ded) (applies to Max OOP)	$12,500 / $25,000 [15] (combined Med/Rx ded) (applies to Max OOP)
Dr. Office Visits (PCP)	65%	50%	65%	50%
Hospital Services - In-Patient	65%	50% (up to $650 per day) [9]	65%	50% (up to $650 per day) [9]
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 ded) [6, 23]	Not Covered	Level 1 $20 Copay / Level 2 $20 Copay (combined Med/Rx ded) [6, 23]	Not Covered
Rx Benefits - Formulary Brand	Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx ded) [6, 23]	Not Covered	Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx ded) [6, 23]	Not Covered
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [17]	$14,700 / $29,400 [17]	$7,350 / $14,700 [17]	$14,700 / $29,400 [17]
Out-Patient Surgical Facility	$250 Copay per admit – 65%	50% (up to $380 per admit) [9]	$250 Copay per admit –65%	50% (up to $380 per admit) [9]
Ambulance (per trip)	65% [21]	65% [21]	65% [21]	65% [21]

Medical Benefits	PPO C ‡		PPO D ‡	
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*	$6,000 / $12,000 [15] (applies to Max OOP)	$12,000 / $24,000 [15] (applies to Max OOP)	$6,000 / $12,000 [15] (applies to Max OOP)	$12,000 / $24,000 [15] (applies to Max OOP)
Dr. Office Visits (PCP)	$65 Copay	50%	$65 Copay	50%
Hospital Services - In-Patient	60%	50% (up to $650 per day) [9]	60%	50% (up to $650 per day) [9]
In-Patient Physician Fees	60%	50%	60%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 60%	$250 Copay – 60%	$250 Copay – 60%	$250 Copay – 60%
Rx Benefits - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived) [23]	Not Covered	Level 1 $20 Copay / Level 2 $20 Copay (ded waived) [23]	Not Covered
Rx Benefits - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay [23]	Not Covered	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay [23]	Not Covered
Out-of-Pocket Max Ind/Fam	$8,500 / $17,000 [17]	$17,000 / $34,000 [17]	$8,500 / $17,000 [17]	$17,000 / $34,000 [17]
Out-Patient Surgical Facility	$250 Copay per admit – 60%	50% (up to $380 per admit) [9]	$250 Copay per admit – 60%	50% (up to $380 per admit) [9]
Ambulance (per trip)	60% [21]	60% [21]	60% [21]	60% [21]

(Footnotes on page 51)



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

- Pet Insurance
- Employee Discounts
- Vision
- Dental
- Hearing
- Rx Discounts
- Fitness and Wellness Discounts

Included in the Business Solutions Suite

- COBRA Billing
- Flexible Spending Accounts
- Premium Only Plan (POP)

Dental

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					
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

Coverage discounts equal 58% and are dental provider specific. Please see dentegrasmileclub.com and click on "Find a Dentist" for a list of dental providers.

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

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.

(Continued on page 35)

Dental *(continued)*

	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.

(Continued on page 36)



Dental *(continued)*

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 if 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.



Vision

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.

Vision *(continued)*

	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		(1 per 12 months)		(1 per 12 months)	
Single Vision	$50	$10	Up to $20 reimbursement	$10	Up to $30 reimbursement
Bifocal	$70	$10	Up to $30 reimbursement	$10	Up to $50 reimbursement
Trifocal	$105	$10	Up to $40 reimbursement	$10	Up to $65 reimbursement
Standard-progressive (No line bifocals; Amount added to bifocal cost)	$65	$75	Up to $30 reimbursement	$55	Up to $50 reimbursement
Lens Options		(in addition to lens copayment above)		(in addition to lens copayment above)	
Polycarbonate	$40	$40	Not Covered	Covered in full for dependent children, $33 adults	Not Covered
Scratch-resistant coating	$15	$15	Not Covered	$17 - $33	Not Covered
Ultraviolet coating	$15	$15	Not Covered	$16	Not Covered
Solid or gradient tint	$15	$15	Not Covered	$15 - $17	Not Covered
Photochromic	20% off retail price	20% off of retail price	Not Covered	$31 - $82	Not Covered
Anti-reflective coating	$45	$45	Not Covered	$43 - $85	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

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 and AD&D

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.



Pet Insurance

Included in the Member Value Suite

Protect Your Pets & Your Wallet

As a CaliforniaChoice® member, you have access to **exclusive pet insurance options** from two leading providers – **MetLife** and **Spot**. That means you can keep your pets safe and healthy while avoiding expensive vet bills.

Your Pet, Your Choice

Choose from **MetLife** or **Spot** to find the right coverage for your furry friends. Pet insurance can help you cover the costs of:

- **Vet Visits**
  Regular check-ups to help protect your pet
- **Accidents**
  For when the unexpected happens
- **Illness**
  To help cover costs for unplanned illness
- **Dental Exams**
  To prevent dental disease and tooth loss
- **Prescription Foods**
  For specific medical conditions

Special Discounts for CaliforniaChoice Members

(Continued on page 42)

Pet Insurance *(continued)*

Peace Of Mind For You, Quality Care For Your Pet

MetLife

- **Special 5% discount for CaliforniaChoice® members**
- **Family plan** to cover up to three pets under the same policy with one deductible and annual limit
- Additional **discounts up to 30%** available for military/veteran, multi-policy, active health care workers, and first responders*
- **Customizable Plan Options** to fit your needs
  - Deductible ($0-$2,500)
  - Annual Limit ($500 or Unlimited)
  - Reimbursement (50% to 90%)
- Optional **preventive care** coverage for flea, tick, and heartworm medications, spaying and neutering, vaccinations, teeth cleanings, wellness exams, fecal and heartworm tests
- Visit any U.S. veterinarian, with reimbursement up to 90% of costs
- **24/7 Telehealth** access along with **concierge services** for immediate assistance
- Coverage of previously covered **pre-existing conditions** when switching providers

Learn About MetLife Pet Insurance

spot pet insurance

- **Special 10% discount for CaliforniaChoice members****
- Additional **10% multiple pet discount***** for other enrolled pets
- **24/7 Telehealth** helpline with vet experts for your pet
- **Flexible plans** for every budget and pet's needs
- **Simple claims process** for hassle-free reimbursements that cover:
  - Vet Exam Fees****
  - Dental Illnesses
  - Surgery & Unexpected Emergencies
  - Diagnostics, X-rays, & Tests
  - Cancer & Growths
  - Microchip Implantation
  - Prescription Medications + More

Learn About Spot Pet Insurance

Give Your Pet the Best Care

Don't wait until the unexpected happens. Get peace of mind and financial protection with pet insurance today. Log into calchoice.com and visit your **Member Value Suite** to learn more about your options and to sign up.

*Military, Veteran, First Responder, & Healthcare Workers (10%), Multi-Policy (Second Policy 5%, Third+ Policy 10%), Animal Care Discount (10%). When using multiple discounts, discounts cannot exceed 30%. Each discount may not be available in all states. Please contact MetLife Pet for further details.

**10% group discount available on every pet. Not available in HI or TN.

***10% multi-pet discount available on all pets after the first.

****Exam fees for wellness or annual exams are not covered unless you have purchased the optional preventive care coverage.

CaliforniaChoice is not a licensed insurance agency nor an underwriter of insurance but may receive compensation for referrals. Waiting periods, annual deductible, co-insurance, benefit limits, and exclusions may apply. For all terms, visit https://spotpet.com/sample-policy. Products, schedules, discounts, and rates may vary and are subject to change. Premiums are based on and may increase or decrease due to the age of your pet, the species or breed of your pet, and your home address. Insurance plans are underwritten by Independence American Insurance Company (NAIC #26581), a Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254, or United States Fire Insurance Company (NAIC #21113), Morristown, NJ), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385). 990 Biscayne Boulevard Suite 603, Miami, FL 33132. CA License #6000188.



Hearing Program

Included in the Member Value Suite

Hearing Program

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

TIP

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

Prescription Discounts

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 **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

Included in the Member Value Suite

Free Employee Discounts From Cal Perks

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

Included in the Member Value Suite

Fitness and Wellness Discounts

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 $28 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



Payroll Services

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

Included in the Business Solutions Suite

Cal-COBRA and Federal COBRA Billing

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.

Included in the Business Solutions Suite

Flexible Spending Account (FSA)

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

Included in the Business Solutions Suite

Section 125 Premium Only Plan (POP)

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 7.1.2025

Platinum HMO

(Footnotes for pages 10-15)

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/Public/Forms) 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 up to four times the retail cost share. 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. 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.
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. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or 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. 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.

Gold HMO

(Footnotes for pages 17-23)

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/Public/Forms) 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 Plan 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 Plan pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plan 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 $3,300 for 2025 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.
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 up to four times the retail cost share. 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. $1,750 Self only enrollment, $3,300 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.
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.

Additional Footnotes

Groups Beginning 7.1.2025

Gold HMO

(Footnotes continued from page 48 for pages 17-23)

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. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or 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.

Gold PPO

(Footnotes for pages 24)

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/Public/Forms) 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.

Silver HMO

(Footnotes for pages 25-28)

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/Public/Forms) 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 or medication.
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 Plan 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 Plan pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plan 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 $3,300 for 2025 plans.
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,

Additional Footnotes

Groups Beginning 7.1.2025

Silver HMO

(Footnotes continued from page 49 for pages 25-28)

.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. 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. 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. $2,850 Self only enrollment, $3,300 for any one member within a Family enrollment. $5,700 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. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or 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.

Silver PPO

(Footnotes for page 29)

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/Public/Forms) 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.
7. Includes telemedicine services at applicable PCP/Specialist cost share.
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.

Additional Footnotes

Groups Beginning 7.1.2025

Bronze HMO & PPO

(Footnotes for page 30-32)

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/Public/Forms) 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 or medication.
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, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
6. Deductible is waived for drugs on the PreventiveRx Plus drug list.
7. Includes telemedicine services at applicable PCP/Specialist cost share.
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. Amount listed is maximum paid by Anthem.
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 Plan 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 Plan pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plan 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 $3,300 for 2025 plans.

Bronze HMO & PPO

(Footnotes continued for pages 30-32)

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. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
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 up to four times the retail cost share. 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. 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.
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. 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.
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.
21. Medical emergency only.
22. If a Tier 1 medication is available but the member elects to receive a medication from Tier 2, 3 or 4 without medical indication from the Prescribing Provider, the member will be responsible for the applicable Tier 2-4 copayment plus the difference in cost between the Tier 1 medication and the purchased medication. The amount paid for the difference in cost does not apply to the deductible (when applicable) or 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.

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