BENEFIT SUMMARIES

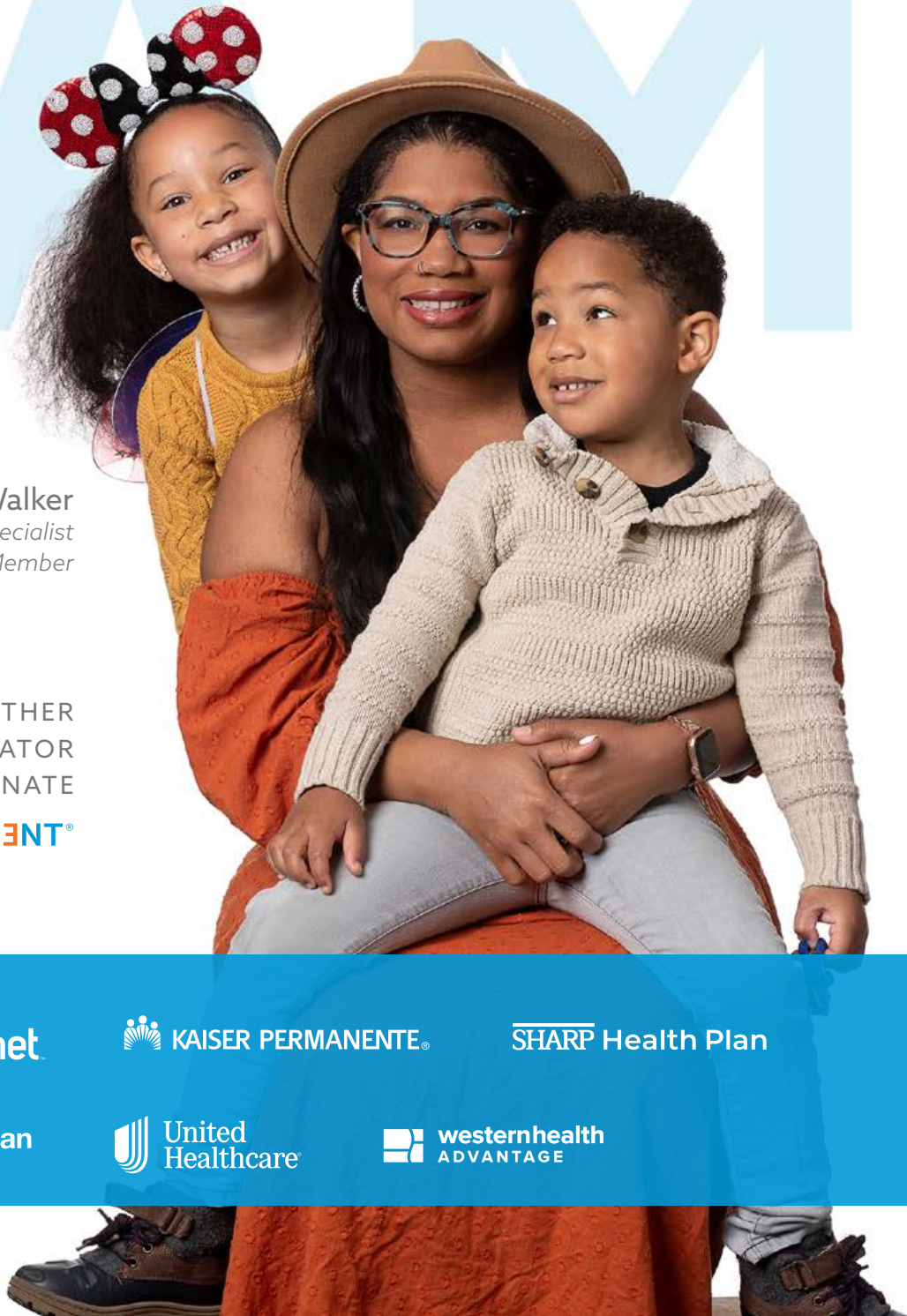
CaliforniaChoice®
Your Health. Your Choice.®

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 1.1.2026

Platinum

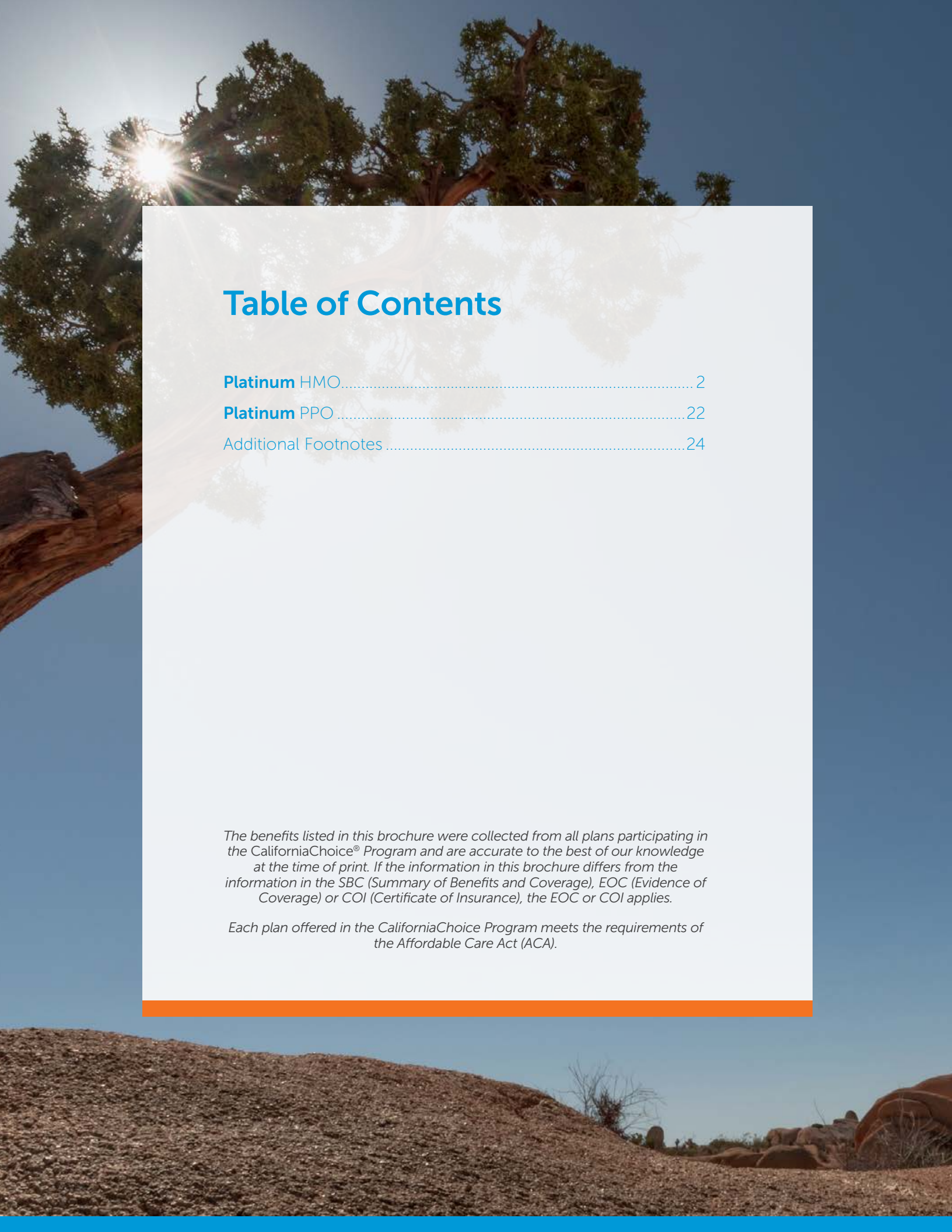


Chanais Walker
Knowledge Management & Learning Specialist
*and **CaliforniaChoice**® Member*

A WIFE & MOTHER
A CREATOR
PASSIONATE

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).

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO A	HMO B	HMO C
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Network Name	Select HMO	Vivity	Vivity
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,500 / $5,000 [9]	$3,350 / $6,700 [9]	$2,500 / $5,000 [9]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$20 Copay	$15 Copay
Specialist Visit (SPC)	$40 Copay	$40 Copay	$30 Copay
Laboratory	$10 Copay [7]	$25 Copay [7]	$25 Copay [7]
X-Ray	$10 Copay [7]	$25 Copay [7]	$25 Copay [7]
MRI, CT and PET (office setting)	$100 Copay [5]	$100 Copay [5]	$100 Copay [5]
Virtual/Telemedicine Office Visit	$20 Copay / $40 Copay [2]	100% / $40 Copay [2]	100% / $30 Copay [2]
Hospital Services – In-Patient	$300 Copay per day – 3 days max per admit	$250 Copay per day – 4 days max per admit	$500 Copay per day – 4 days max per admit
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$150 Copay	$500 Copay
Urgent Care	$20 Copay	$20 Copay	$15 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay $200 Copay	 $150 Copay $150 Copay	 $500 Copay $500 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$40 Copay	$30 Copay
Ambulance Services (per trip)	$150 Copay [15]	$150 Copay [15]	$500 Copay [15]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $5 Copay / Level 2 $15 Copay [10] Level 1 $20 Copay / Level 2 $30 Copay [10] Level 1 $50 Copay / Level 2 $60 Copay [10] Level 1 70% / Level 2 60% (up to $250 per prescription [14]) (prior auth. required) [10,12]	 Level 1 $5 Copay / Level 2 $15 Copay [10] Level 1 $25 Copay / Level 2 $35 Copay [10] Level 1 $75 Copay / Level 2 $85 Copay [10] Level 1 $250 Copay / Level 2 $250 Copay (prior auth. required) [10,12]	 Level 1 $5 Copay / Level 2 $15 Copay [10] Level 1 $25 Copay / Level 2 $35 Copay [10] Level 1 $75 Copay / Level 2 $85 Copay [10] Level 1 $250 Copay / Level 2 $250 Copay (prior auth. required) [10,12]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [10]	Applicable Rx Copay [10]	Applicable Rx Copay [10]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered [1]	Covered [1]	Covered [1]
Chemotherapy	$40 Copay	$40 Copay	$30 Copay
Chiropractic (20 visits max per year)	$15 Copay (30 visits max per benefit period) [8]	$15 Copay (30 visits max per benefit period) [8]	$15 Copay (30 visits max per benefit period) [8]
Acupuncture	$20 Copay	$20 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$20 Copay [7]	$30 Copay [7]	$30 Copay [7]
Rehabilitative & Habilitative Services and Devices	$20 Copay [7]	$30 Copay [7]	$30 Copay [7]
Home Health Care (Max 100 visits per year)	$40 Copay (Max 100 visits per benefit period) [11]	$40 Copay (Max 100 visits per benefit period) [11]	$30 Copay (Max 100 visits per benefit period) [11]

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO A	HMO B	HMO C
Participating Health Plans	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
Network Name	Select HMO	Vivity	Vivity
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$100 Copay per day – 3 days max per admit [6]	$150 Copay per day – 4 days max per admit [6]	$150 Copay per day – 4 days max per admit [6]
Hospice (out-patient)	100%	$40 Copay	$30 Copay
Durable Medical Equipment (Covered when medically necessary)	50%	$100 Copay	$100 Copay
Mental Health			
In-Patient	$300 Copay per day – 3 days max per admit	$250 Copay per day – 4 days max per admit	$500 Copay per day – 4 days max per admit
Out-Patient (office visit)	$20 Copay	$20 Copay	$15 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$300 Copay per day – 3 days max per admit	$250 Copay per day – 4 days max per admit	$500 Copay per day – 4 days max per admit
Infertility			
Infertility Evaluation and Treatment	$20 Copay [13]	$20 Copay [13]	$15 Copay [13]
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision	Blue View Vision	Blue View Vision
Exam	100%	100%	100%
Contact Lenses	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	100% (in lieu of eyeglasses)
Frames	100%	100%	100%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime	Prime	Prime
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%

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

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

1. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.
2. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
3. 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.
4. See plan specific EOC for information on preventive services.
5. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
6. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Manipulation Therapy only: benefit maximum of 30 visits per benefit period for office visits.
9. 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.
10. 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.
11. Limited to 100 4-hour visits per benefit period.
12. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
13. Evaluation only.
14. Maximum member responsibility.
15. Medical emergency only.

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO D	HMO C	HMO E
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	CaliforniaCare HMO	WholeCare	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$2,100 / $4,200 [12]	$2,700 / $5,400	$2,700 / $5,400
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$30 Copay	$30 Copay
Specialist Visit (SPC)	$40 Copay	$50 Copay	$50 Copay
Laboratory	$10 Copay [7]	$30 Copay	$30 Copay
X-Ray	$10 Copay [7]	$30 Copay	$30 Copay
MRI, CT and PET (office setting)	$100 Copay [11]	$250 Copay per procedure	$250 Copay per procedure
Virtual/Telemedicine Office Visit	$20 Copay / $40 Copay [19]	100%	100%
Hospital Services – In-Patient	$500 Copay per admit	$600 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)	$300 Copay	$250 Copay	$250 Copay
Urgent Care	$20 Copay	$30 Copay	$30 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $150 Copay $100 Copay	 $500 Copay $200 Copay [1]	 $500 Copay $200 Copay [1]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$40 Copay	$50 Copay	$50 Copay
Ambulance Services (per trip)	$150 Copay [17]	$250 Copay	$250 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $5 Copay / Level 2 $15 Copay [18] Level 1 $20 Copay / Level 2 $30 Copay [18] Level 1 $50 Copay / Level 2 $60 Copay [18] Level 1 70% / Level 2 60% (up to $250 per prescription [5]) (prior auth. required) [14, 19]	 $5 Copay [2, 4] $30 Copay [2, 4] $50 Copay [2, 4] 70% (up to $250 per prescription [5]) (prior auth. required) [2, 4]	 $5 Copay [2, 4] $30 Copay [2, 4] $50 Copay [2, 4] 70% (up to $250 per prescription [5]) (prior auth. required) [2, 4]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [18]	Applicable Rx Copay [2, 4]	Applicable Rx Copay [2, 4]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [6]	100% [6]	100% [6]
Chronic Disease Management	Covered [16]	$50 Copay	$50 Copay
Chemotherapy	$40 Copay	$30 Copay	$30 Copay
Chiropractic (20 visits max per year)	$15 Copay (30 visits max per benefit period) [20]	Not Covered	Not Covered
Acupuncture	$20 Copay	$15 Copay [3]	$15 Copay [3]
Physical, Occupational, Speech Therapy	$20 Copay [7]	$30 Copay [7]	$30 Copay [7]
Rehabilitative & Habilitative Services and Devices	$20 Copay [7]	$30 Copay [7]	$30 Copay [7]
Home Health Care (Max 100 visits per year)	$40 Copay (Max 100 visits per benefit period) [13]	$30 Copay	$30 Copay

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO D	HMO C	HMO E
Participating Health Plans	Anthem Blue Cross	Health Net	Health Net
Network Name	CaliforniaCare HMO	WholeCare	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$100 Copay per admit [21]	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	70%	70%
Mental Health			
In-Patient	$500 Copay per admit	$600 Copay per day – 4 days max [8]	$600 Copay per day – 4 days max [8]
Out-Patient (office visit)	$20 Copay	$30 Copay [8]	$30 Copay [8]
Drug/Substance Abuse			
In-Patient (Detox Only)	$500 Copay per admit	$600 Copay per day – 4 days max	$600 Copay per day – 4 days max
Infertility			
Infertility Evaluation and Treatment	$20 Copay [15]	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Anthem Vision	EyeMed [9]	EyeMed [9]
Network	Blue View Vision	EyeMed	EyeMed
Exam	100%	100%	100%
Contact Lenses	100% (in lieu of eyeglasses)	100%	100%
Frames	100%	1 pair per calendar year	1 pair per calendar year
Maximum Allowance per year	1 per calendar year	None	None
Pediatric Dental			
Carrier	Anthem Dental	Dental Benefit Providers [9, 10]	Dental Benefit Providers [9, 10]
Network	Prime	Dental Benefit Providers	Dental Benefit Providers
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	80%	Copay varies by service	Copay varies by service
Major Services (no waiting period)	50%	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	50%	Copay varies by service	Copay varies by service

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

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

1. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
2. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
3. Must be medically necessary.
4. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
5. Maximum member responsibility.
6. See plan specific EOC for information on preventive services.
7. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
8. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
9. Pediatric dental and vision are included on all plans.
10. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
11. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
12. 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.
13. Limited to 100 4-hour visits per benefit period.
14. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
15. Evaluation only.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.
17. Medical emergency only.
18. 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.
19. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 copay for virtual visits through online provider – LiveHealth Online.
20. Manipulation Therapy only: benefit maximum of 30 visits per benefit period for office visits.
21. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO F	HMO G	HMO H
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	Salud HMO y Mas	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,250 / $8,500	$4,250 / $8,500 [11]	$4,250 / $8,500
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	100%	100%
Specialist Visit (SPC)	100%	100%	100%
Laboratory	100%	100%	100%
X-Ray	100%	100%	100%
MRI, CT and PET (office setting)	$275 Copay per procedure	$275 Copay per procedure	$275 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$275 Copay	$275 Copay
Urgent Care	100%	100%	100%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $200 Copay [8]	 $500 Copay $200 Copay [8]	 $500 Copay $200 Copay [8]
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	100%	100%	100%
Ambulance Services (per trip)	$275 Copay	$275 Copay	$275 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% [6, 10] $30 Copay [6, 10] $50 Copay [6, 10] 70% (up to $250 per prescription [9]) (prior auth. required) [6, 10]	 100% [6, 10] $30 Copay [6, 10] $50 Copay [6, 10] 70% (up to $250 per prescription [9]) (prior auth. required) [6, 10]	 100% [6, 10] $30 Copay [6, 10] $50 Copay [6, 10] 70% (up to $250 per prescription [9]) (prior auth. required) [6, 10]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [6, 10]	Applicable Rx Copay [6, 10]	Applicable Rx Copay [6, 10]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [5]	100% [5]	100% [5]
Chronic Disease Management	100%	100%	100%
Chemotherapy	100%	100%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$15 Copay [2]	$15 Copay [2]	$15 Copay [2]
Physical, Occupational, Speech Therapy	100% [3]	100% [3]	100% [3]
Rehabilitative & Habilitative Services and Devices	100% [3]	100% [3]	100% [3]
Home Health Care (Max 100 visits per year)	100%	100%	100%

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO F	HMO G	HMO H
Participating Health Plans	Health Net	Health Net	Health Net
Network Name	WholeCare	Salud HMO y Mas	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$25 Copay per day (no limit)
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	70%	70%
Mental Health			
In-Patient	$500 Copay per day – 4 days max [1]	$500 Copay per day – 4 days max [1]	$500 Copay per day – 4 days max [1]
Out-Patient (office visit)	100% [1]	100% [1]	100% [1]
Drug/Substance Abuse			
In-Patient (Detox Only)	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max	$500 Copay per day – 4 days max
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	EyeMed [7]	EyeMed [7]	EyeMed [7]
Network	EyeMed	EyeMed	EyeMed
Exam	100%	100%	100%
Contact Lenses	100%	100%	100%
Frames	1 pair per calendar year	1 pair per calendar year	1 pair per calendar year
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Dental Benefit Providers [4, 7]	Dental Benefit Providers [4, 7]	Dental Benefit Providers [4, 7]
Network	Dental Benefit Providers	Dental Benefit Providers	Dental Benefit Providers
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	Copay varies by service	Copay varies by service	Copay varies by service

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

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

1. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
2. Must be medically necessary.
3. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
4. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
5. See plan specific EOC for information on preventive services.
6. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
7. Pediatric dental and vision are included on all plans.
8. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
9. Maximum member responsibility.
10. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.
11. 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.

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO I	HMO J	HMO A
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	SmartCare	SmartCare	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,250 / $8,500	$2,700 / $5,400	$3,000 / $6,000 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	$30 Copay	$10 Copay
Specialist Visit (SPC)	100%	$50 Copay	$20 Copay
Laboratory	100%	$30 Copay	$20 Copay
X-Ray	100%	$30 Copay	$40 Copay
MRI, CT and PET (office setting)	$275 Copay per procedure	$250 Copay per procedure	$150 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$500 Copay per day - 4 days max	$600 Copay per day - 4 days max	$500 Copay per admit
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$275 Copay	$250 Copay	$200 Copay
Urgent Care	100%	$30 Copay	$10 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $500 Copay $200 Copay [18]	 $500 Copay $200 Copay [18]	 $300 Copay per procedure $300 Copay per procedure
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	100%	$50 Copay	$20 Copay
Ambulance Services (per trip)	$275 Copay	$250 Copay	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% [16, 19] $30 Copay [16, 19] $50 Copay [16, 19] 70% (up to $250 per prescription [3]) (prior auth. required) [16, 19]	 $5 Copay [16, 19] $30 Copay [16, 19] $50 Copay [16, 19] 70% (up to $250 per prescription [3]) (prior auth. required) [16, 19]	 $5 Copay $15 Copay $15 Copay (with physician approval) 90% (up to $250 per prescription [3]) (with physician approval)
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay [16, 19]	Applicable Rx Copay [16, 19]	$15 Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	100%	$50 Copay	Covered as any Illness
Chemotherapy	100%	$30 Copay	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	$15 Copay [10]
Acupuncture	$15 Copay [13]	$15 Copay [13]	$10 Copay [10]
Physical, Occupational, Speech Therapy	100% [14]	$30 Copay [14]	$10 Copay
Rehabilitative & Habilitative Services and Devices	100% [14]	$30 Copay [14]	$10 Copay

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO I	HMO J	HMO A
Participating Health Plans	Health Net	Health Net	Kaiser Permanente
Network Name	SmartCare	SmartCare	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Home Health Care (Max 100 visits per year)	100%	$30 Copay	100% [5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$25 Copay per day (no limit)	$25 Copay per day (no limit)	$250 Copay per admit
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	70%	70%	90% [6, 11]
Mental Health			
In-Patient	$500 Copay per day – 4 days max [12]	$500 Copay per day – 4 days max [12]	$500 Copay per admit
Out-Patient (office visit)	100% [12]	$30 Copay [12]	$10 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$500 Copay per day – 4 days max	$600 Copay per day – 4 days max	$500 Copay per admit
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	EyeMed [17]	EyeMed [17]	Kaiser Permanente
Network	EyeMed	EyeMed	Kaiser Permanente
Exam	100%	100%	100%
Contact Lenses	100%	100%	1 pair per calendar year [9]
Frames	1 pair per calendar year	1 pair per calendar year	1 pair per calendar year [9]
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Dental Benefit Providers [15, 17]	Dental Benefit Providers [15, 17]	Delta Dental
Network	Dental Benefit Providers	Dental Benefit Providers	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	$350 / $700
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	$40 Copay [7]
Major Services (no waiting period)	Copay varies by service	Copay varies by service	$365 Copay [8]
Orthodontics (medically necessary)	Copay varies by service	Copay varies by service	$350 Copay

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

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

1. Under a family contract, when an insured satisfies the individual deductible amount, no further deductible is required for that insured for the remainder of that calendar year; however, an insured may not contribute an amount greater than the individual deductible toward the family deductible.
2. Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximun per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
6. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
7. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
8. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
9. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
10. 20 visits max per year combined for Chiropractic and Acupuncture.
11. Supplemental Durable Medical Equipment has a $2,000 annual maximum.
12. Benefits are administered by MHN Services, an affiliate behavioral health administrative services company which provides behavioral health services.
13. Must be medically necessary.
14. Amount listed is for office visits only, please see plan specific EOC for other settings/ services and devices cost shares.
15. The pediatric dental benefits are provided by Health Net and administered by Dental Benefit Providers of California, Inc. (DBP). DBP is a California licensed specialized dental plan and is not affiliated with Health Net. Additional pediatric dental benefits are covered. See the plan's EOC for details.
16. See plan specific EOC for information regarding preventive drugs and women's contraceptives.
17. Pediatric dental and vision are included on all plans.
18. Cost share varies depending on type of service, see plan specific EOC for cost shares of other service types.
19. The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty.

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO B	HMO C	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	$250/ $500 [11] (combined Med/Rx ded) (applies to Max OOP)	None
Out-of-Pocket Max Ind/Fam	$4,500 / $9,000 [12]	$3,250 / $6,500 [12]	$6,850 / $13,700 [3]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$30 Copay (ded waived)	$15 Copay
Specialist Visit (SPC)	$30 Copay	$50 Copay (ded waived)	$25 Copay
Laboratory	$20 Copay	$30 Copay (ded waived)	100%
X-Ray	$30 Copay	$50 Copay (ded waived)	100%
MRI, CT and PET (office setting)	$100 Copay per procedure	$150 Copay (ded waived) per procedure	$150 Copay
Virtual/Telemedicine Office Visit	100%	100% (ded waived)	Covered as any Illness
Hospital Services – In-Patient	$250 Copay per day – 5 days max	$500 Copay per admit	$400 Copay
In-Patient Physician Fees	100%	100% (ded waived)	100%
Emergency Room (copay waived if admitted)	$150 Copay	$250 Copay (ded waived)	$200 Copay
Urgent Care	$20 Copay	$30 Copay (ded waived)	$25 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $125 Copay per procedure $125 Copay per procedure	 $300 Copay (ded waived) per procedure $300 Copay (ded waived) per procedure	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$30 Copay	$50 Copay (ded waived)	$25 Copay
Ambulance Services (per trip)	$150 Copay	$150 Copay (ded waived)	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay $20 Copay $20 Copay (with physician approval) 90% (up to $250 per prescription [10]) (with physician approval)	 $10 Copay (ded waived) $20 Copay (ded waived) $20 Copay (ded waived) (with physician approval) 90% (up to $250 per prescription [10]) (combined Med/Rx ded) (with physician approval)	 $10 Copay $25 Copay $50 Copay 90% (up to $250 per prescription [10])
Oral Contraceptives	100%	100% (ded waived)	100% (if in formulary)
Diabetes – Self-Injectable	$20 Copay	$20 Copay (ded waived)	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	$400 Copay [7]
Preventive/Wellness Services	100% [4]	100% (ded waived) [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	$25 Copay
Chemotherapy	90%	100% (ded waived)	Variable [6]
Chiropractic (20 visits max per year)	Not Covered	$15 Copay (ded waived) [18]	Not Covered
Acupuncture	$20 Copay	$30 Copay (ded waived) [18]	$15 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$30 Copay (ded waived)	$15 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$30 Copay (ded waived)	$15 Copay

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO B	HMO C	HMO A
Participating Health Plans	Kaiser Permanente	Kaiser Permanente	Sharp Health Plan
Network Name	Full	Full	Premier
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Home Health Care (Max 100 visits per year)	$20 Copay [13]	100% (ded waived) [13]	$15 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 5 days max	$250 Copay per admit	$200 Copay
Hospice (out-patient)	100%	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	90% [14, 19]	90% [14, 19]	50%
Mental Health In-Patient Out-Patient (office visit)	 $250 Copay per day – 5 days max $20 Copay	 $500 Copay per admit $30 Copay (ded waived)	 $400 Copay $15 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $250 Copay per day – 5 days max	 $500 Copay per admit	 $400 Copay
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Kaiser Permanente Kaiser Permanente 100% 1 pair per calendar year [17] 1 pair per calendar year [17] None	 Kaiser Permanente Kaiser Permanente 100% (ded waived) 1 pair per calendar year [17] 1 pair per calendar year (ded waived) [17] None	 VSP VSP Advantage Network 100% 1 pair in lieu of eyeglasses 100% (Pediatric Exchange collection only) None
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Delta Dental DeltaCare USA None $350 / $700 100% 100% $40 Copay [15] $365 Copay [16] $350 Copay	 Delta Dental DeltaCare USA None $350 / $700 100% (ded waived) 100% (ded waived) $40 Copay [15] $365 Copay [16] $350 Copay	 Delta Dental of California Delta Dental DeltaCare USA None Combined with Medical 100% [5] 100% [8] $25 Copay [1] $300 Copay [2] $1,000 Copay [9]

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

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

1. Refers to procedure code D2140
2. Refers to procedure code D3330
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. See plan specific EOC for information on preventive services.
5. Refers to procedure code D0999
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Amount listed for In-Patient Services only.
8. Refers to procedure codes D0120 and D1120/D1110
9. Refers to procedure code D8080/D8090
10. Maximum member responsibility.
11. 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.
12. 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.
13. Home Health Care visit part-time/intermittent coverage (2 hour(s) maximun per visit(s), 3 visit(s) maximum per day(s), 100 visit(s) maximum per calendar year).
14. Certain prosthetics, orthotics and devices may be available at no cost (after deductible, if deductible applies). Please refer to the Evidence of Coverage for more information on Durable Medical Equipment (DME), prosthetics, orthotics and devices. Most DME for home use, prosthetics, orthotics and devices are not covered.
15. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
16. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average copay charged for procedures in this category cannot exceed the stated amount.
17. 1 pair of glasses or 1 pair of contact lenses per accumulation period.
18. 20 visits max per year combined for Chiropractic and Acupuncture.
19. Supplemental Durable Medical Equipment has a $2,000 annual maximum.

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO B	HMO C	HMO A
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sutter Health Plan
Network Name	Performance	Premier	Sutter Health Plan
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,200 / $8,400 [3]	$4,400 / $8,800 [3]	$4,500 / $9,000 [11]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$20 Copay	$10 Copay	$20 Copay [14]
Specialist Visit (SPC)	$30 Copay	$20 Copay	$30 Copay
Laboratory	100%	$10 Copay	$20 Copay
X-Ray	100%	$40 Copay	$30 Copay per procedure
MRI, CT and PET (office setting)	$100 Copay	$150 Copay	$100 Copay per procedure
Virtual/Telemedicine Office Visit	Covered as any Illness	Covered as any Illness	Variable [13]
Hospital Services – In-Patient	85%	$350 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit
In-Patient Physician Fees	85%	100%	100%
Emergency Room (copay waived if admitted)	85%	$200 Copay	$150 Copay
Urgent Care	$30 Copay	$20 Copay	$20 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 85% 85%	 80% 80%	 $100 Copay $100 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$30 Copay	$20 Copay	$30 Copay
Ambulance Services (per trip)	85%	$200 Copay	$150 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $25 Copay $50 Copay 90% (up to $250 per prescription [5])	 $10 Copay $25 Copay $50 Copay 90% (up to $250 per prescription [5])	 $5 Copay [12] $20 Copay [12] $30 Copay [12] 90% (up to $250 per prescription [5]) [12]
Oral Contraceptives	100% (if in formulary)	100% (if in formulary)	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay	Applicable Rx Copay [12]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	85% [7]	$350 Copay per day – 5 days max [7]	Covered as any Illness
Preventive/Wellness Services	100% [1]	100% [1]	100% [1]
Chronic Disease Management	$30 Copay	$20 Copay	Covered as any Illness
Chemotherapy	Variable [6]	Variable [6]	90%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$20 Copay	$10 Copay	$20 Copay
Physical, Occupational, Speech Therapy	$20 Copay	$10 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$20 Copay	$10 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$10 Copay	$20 Copay

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO B	HMO C	HMO A
Participating Health Plans	Sharp Health Plan	Sharp Health Plan	Sutter Health Plan
Network Name	Performance	Premier	Sutter Health Plan
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	85%	$200 Copay	$150 Copay per day – 5 days max per admit
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	50%	50%	90%
Mental Health			
In-Patient	85%	$150 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit [9]
Out-Patient (office visit)	$20 Copay	$10 Copay	$20 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	85%	$150 Copay per day – 5 days max	$250 Copay per day – 5 days max per admit [9]
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	VSP	VSP	VSP
Network	VSP Advantage Network	VSP Advantage Network	Choice Network
Exam	100%	100%	100% [8]
Contact Lenses	1 pair in lieu of eyeglasses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses) [8, 10]
Frames	100% (Pediatric Exchange collection only)	100% (Pediatric Exchange collection only)	100% (in lieu of contact lenses) [8, 10]
Maximum Allowance per year	None	None	1 pair per year
Pediatric Dental			
Carrier	Delta Dental of California	Delta Dental of California	Delta Dental
Network	Delta Dental DeltaCare USA	Delta Dental DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100% [4]	100% [4]	Copay varies by service
Diagnostic & Preventative (D&P)	100% [17]	100% [17]	100%
Basic Services	$25 Copay [15]	$25 Copay [15]	Copay varies by service
Major Services (no waiting period)	$300 Copay [2]	$300 Copay [2]	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay [16]	$1,000 Copay [16]	$1,000 Copay

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

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

1. See plan specific EOC for information on preventive services.
2. Refers to procedure code D3330
3. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.
4. Refers to procedure code D0999
5. Maximum member responsibility.
6. Copay/Coinsurance waived if seen by nurse or in an out-patient setting.
7. Amount listed for In-Patient Services only.
8. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
9. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; substance use disorder treatment for withdrawal; inpatient behavioral health treatment for autism spectrum disorder.
10. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every calendar year.
11. 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.
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. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.
14. 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.
15. Refers to procedure code D2140
16. Refers to procedure code D8080/D8090
17. Refers to procedure codes D0120 and D1120/D1110

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	SignatureValue	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$4,000 / $8,000 [1]	$2,500 / $5,000 [1]	$4,000 / $8,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$30 Copay	$20 Copay	$30 Copay
Specialist Visit (SPC)	$55 Copay	$40 Copay	$55 Copay
Laboratory	$30 Copay	$20 Copay	$30 Copay
X-Ray	$30 Copay	$20 Copay	$30 Copay
MRI, CT and PET (office setting)	$250 Copay per procedure	$150 Copay per procedure	$250 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	80%	$300 Copay per day – 3 days max per admit	80%
In-Patient Physician Fees	80%	100%	80%
Emergency Room (copay waived if admitted)	80%	$250 Copay	80%
Urgent Care	$75 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 $200 Copay $200 Copay	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$55 Copay	$40 Copay	$55 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $80 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $50 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $80 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [5]	$150 Copay [5]	$150 Copay [5]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$30 Copay	$20 Copay	$30 Copay
Rehabilitative & Habilitative Services and Devices	$30 Copay	$20 Copay	$30 Copay

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO A	HMO B	HMO C
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	SignatureValue	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Home Health Care (Max 100 visits per year)	$30 Copay	$20 Copay	$30 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	$300 Copay per day – 3 days max per admit	80%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	$70 Copay
Mental Health In-Patient Out-Patient (office visit)	 80% $30 Copay	 $300 Copay per day – 3 days max per admit $30 Copay	 80% $30 Copay
Drug/Substance Abuse In-Patient (Detox Only)	80%	$300 Copay per day – 3 days max per admit	80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% 80% 80% 1 per calendar year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% 90% 90% 1 per calendar year	 UnitedHealthcare Vision UnitedHealthcare Vision 100% 80% 80% 1 per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $350 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $350 Copay	 UnitedHealthcare Dental CA DHMO None Combined with Medical 100% 100% Copay varies by service Copay varies by service $350 Copay

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

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

1. 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.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. 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.

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO E	HMO G	HMO H
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Harmony
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000 [1]	$3,000 / $6,000 [1]	$4,000 / $8,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$25 Copay	$30 Copay
Specialist Visit (SPC)	$50 Copay	$50 Copay	$55 Copay
Laboratory	$25 Copay	$25 Copay	$30 Copay
X-Ray	$25 Copay	$25 Copay	$30 Copay
MRI, CT and PET (office setting)	$150 Copay per procedure	$150 Copay per procedure	$250 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$400 Copay per day – 5 days max per admit	$400 Copay per day – 5 days max per admit	80%
In-Patient Physician Fees	100%	100%	80%
Emergency Room (copay waived if admitted)	$400 Copay	$400 Copay	80%
Urgent Care	$75 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay $250 Copay	 $250 Copay $250 Copay	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$50 Copay	$55 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $40 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $80 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [5]	$150 Copay [5]	$150 Copay [5]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$25 Copay	$30 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$25 Copay	$30 Copay
Home Health Care (Max 100 visits per year)	$25 Copay	$25 Copay	$30 Copay

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO E	HMO G	HMO H
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	SignatureValue	Alliance	Harmony
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day – 5 days max per admit	$300 Copay per day – 5 days max per admit	80%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	$70 Copay
Mental Health			
In-Patient	$400 Copay per day – 5 days max per admit	$400 Copay per day – 5 days max per admit	80%
Out-Patient (office visit)	$30 Copay	$30 Copay	$30 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$400 Copay per day – 5 days max per admit	$400 Copay per day – 5 days max per admit	80%
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100%	100%	100%
Contact Lenses	90%	90%	80%
Frames	90%	90%	80%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	CA DHMO	CA DHMO	CA DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$350 Copay

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

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

1. 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.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. 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.

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO I	HMO M	HMO N
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Harmony	Harmony	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$3,000 / $6,000 [1]	$2,500 / $5,000 [1]	$2,500 / $5,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$20 Copay	$20 Copay
Specialist Visit (SPC)	$50 Copay	$40 Copay	$40 Copay
Laboratory	$25 Copay	$20 Copay	$20 Copay
X-Ray	$25 Copay	$20 Copay	$20 Copay
MRI, CT and PET (office setting)	$150 Copay per procedure	$150 Copay per procedure	$150 Copay per procedure
Virtual/Telemedicine Office Visit	100%	100%	100%
Hospital Services – In-Patient	$400 Copay per day – 5 days max per admit	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$400 Copay	$250 Copay	$250 Copay
Urgent Care	$75 Copay	$75 Copay	$75 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay $250 Copay	 $200 Copay $200 Copay	 $200 Copay $200 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay	$40 Copay	$40 Copay
Ambulance Services (per trip)	$100 Copay	$100 Copay	$100 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $30 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $60 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $50 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]	 Tier 1 Non-specialty $5 Copay / Tier 1 Specialty $5 Copay [6] Tier 2 Non-specialty $20 Copay / Tier 2 Specialty $150 Copay [6] Tier 3 Non-specialty $50 Copay / Tier 3 Specialty $250 Copay [6] Tier 4 75% (up to $250 per prescription [3]) [2]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [4]	100% [4]	100% [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	$150 Copay [5]	$150 Copay [5]	$150 Copay [5]
Chiropractic (20 visits max per year)	$15 Copay	$15 Copay	$15 Copay
Acupuncture	$10 Copay	$10 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$20 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$20 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	$25 Copay	$20 Copay	$20 Copay

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO I	HMO M	HMO N
Participating Health Plans	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Network Name	Harmony	Harmony	Alliance
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$300 Copay per day - 5 days max per admit	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max per admit
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	$70 Copay	$70 Copay	$70 Copay
Mental Health			
In-Patient	$400 Copay per day - 5 days max per admit	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max per admit
Out-Patient (office visit)	$30 Copay	$30 Copay	$30 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$400 Copay per day - 5 days max per admit	$300 Copay per day – 3 days max per admit	$300 Copay per day – 3 days max per admit
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Network	UnitedHealthcare Vision	UnitedHealthcare Vision	UnitedHealthcare Vision
Exam	100%	100%	100%
Contact Lenses	90%	90%	90%
Frames	90%	90%	90%
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental			
Carrier	UnitedHealthcare Dental	UnitedHealthcare Dental	UnitedHealthcare Dental
Network	CA DHMO	CA DHMO	CA DHMO
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$350 Copay

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

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

1. 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.
2. No change to how Specialty Drugs in Tier 4 are filled today.
3. Maximum member responsibility.
4. See plan specific EOC for information on preventive services.
5. In instances where the contracted rate is less than your copayment, you will pay only the contracted rate.
6. 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.

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None	None
Out-of-Pocket Max Ind/Fam	$5,500 / $11,000 [1]	$4,500 / $9,000 [1]	$5,500 / $11,000 [1]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay	$20 Copay	$20 Copay
Specialist Visit (SPC)	$25 Copay	$30 Copay	$20 Copay
Laboratory	100%	$20 Copay	100%
X-Ray	100%	$30 Copay	100%
MRI, CT and PET (office setting)	$100 Copay	$100 Copay	$150 Copay
Virtual/Telemedicine Office Visit	Variable [10]	Variable [10]	Variable [10]
Hospital Services – In-Patient	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5	100%
In-Patient Physician Fees	100%	100%	100%
Emergency Room (copay waived if admitted)	$150 Copay	$150 Copay	$150 Copay
Urgent Care	$50 Copay	$20 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay $200 Copay	 $100 Copay $100 Copay	 $200 Copay $200 Copay
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$25 Copay	$30 Copay	$20 Copay
Ambulance Services (per trip)	100%	$150 Copay	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay $30 Copay [9] $50 Copay [9] 80% (up to $250 per 30 day supply [6]) [3]	 $5 Copay $20 Copay [9] $30 Copay [9] 90% (up to $250 per 30 day supply [6]) [3]	 $10 Copay $30 Copay [9] $50 Copay [9] 80% (up to $250 per 30 day supply [6]) [3]
Oral Contraceptives	100%	100%	100%
Diabetes – Self-Injectable	$30 Copay	$20 Copay	$30 Copay
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% [2, 5]	100% [2, 5]	100% [2, 5]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	90% [3]	100%
Chiropractic (20 visits max per year)	$15 Copay [8]	Not Covered	$15 Copay [8]
Acupuncture	$15 Copay	$20 Copay	$15 Copay
Physical, Occupational, Speech Therapy	$25 Copay	$20 Copay	$20 Copay
Rehabilitative & Habilitative Services and Devices	$25 Copay	$20 Copay	$20 Copay
Home Health Care (Max 100 visits per year)	100%	$20 Copay	100%

Platinum HMO

Groups Beginning 1.1.2026

Services	HMO A	HMO B	HMO C
Participating Health Plans	Western Health Advantage	Western Health Advantage	Western Health Advantage
Network Name	Full	Full	Full
Metal Tier	**Platinum**	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$250 Copay per day – Days 1-5	$150 Copay per day – Days 1-5	100%
Hospice (out-patient)	100%	100%	100%
Durable Medical Equipment (Covered when medically necessary)	80% [3, 4]	90% [3, 4]	80% [3, 4]
Mental Health			
In-Patient	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5	100%
Out-Patient (office visit)	$25 Copay	$20 Copay	$20 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	$250 Copay per day – Days 1-5	$250 Copay per day – Days 1-5	100%
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Vision Service Plan (VSP)	Vision Service Plan (VSP)	Vision Service Plan (VSP)
Network	VSP Advantage	VSP Advantage	VSP Advantage
Exam	100%	100%	100%
Contact Lenses	100%	100%	100%
Frames	100%	100%	100%
Maximum Allowance per year	1 per calendar year [7]	1 per calendar year [7]	1 per calendar year [7]
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental
Network	DeltaCare USA	DeltaCare USA	DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with Medical	Combined with Medical	Combined with Medical
Office Visit	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%
Basic Services	Copay varies by service	Copay varies by service	Copay varies by service
Major Services (no waiting period)	Copay varies by service	Copay varies by service	Copay varies by service
Orthodontics (medically necessary)	$1,000 Copay	$1,000 Copay	$1,000 Copay

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

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

1. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
2. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
3. Percentage copayment amounts are based on WHA's contracted rates with the provider of service or medication.
4. See copayment summary for applicable prosthetic/orthotic device copayment amount.
5. See plan specific EOC for information on preventive services.
6. Maximum member responsibility.
7. Limited to one pair of glasses with standard lenses and provider designated frames or one pair of conventional, six months supply of monthly or 2-week disposable, or 3 months supply of daily disposable contact lenses instead of glasses.
8. Copayments do not contribute to out-of-pocket maximum.
9. 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.
10. Cost share amount varies based on type of services rendered.

Platinum PPO

Groups Beginning 1.1.2026

Services	**PPO B**	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Platinum**	
	In-Network	Out-of-Network [9]
Calendar Year Deductible*	None	$2,000 / $4,000 [17] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000 [1]	$10,000 / $20,000 [1]
Lifetime Maximum	Unlimited	
Dr. Office Visits (PCP)	$10 Copay	50%
Specialist Visit (SPC)	$35 Copay	50%
Laboratory	$10 Copay	50%
X-Ray	$10 Copay	50%
MRI, CT and PET (office setting)	90% [14]	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	$10 Copay / $35 Copay [15]	50%
Hospital Services – In-Patient	90%	50% (up to $650 per day) [5]
In-Patient Physician Fees	90%	50%
Emergency Room (copay waived if admitted)	$500 Copay – 90%	
Urgent Care	$10 Copay	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $200 Copay per admit – 90% $50 Copay per admit – 90%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required	
2nd Surgical Opinion	$35 Copay	50%
Ambulance Services (per trip)	90% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $5 Copay / Level 2 $15 Copay [2] Level 1 $15 Copay / Level 2 $25 Copay [2] Level 1 $45 Copay / Level 2 $55 Copay [2] Level 1 70% / Level 2 60% (up to $250 per prescription [8]) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered
Diabetes – Self-Injectable	Applicable Rx Copay	Not Covered
Pre-Existing Conditions	Covered	
Maternity and Newborn Care	Covered as any Illness	
Preventive/Wellness Services	100% [3]	50% [3]
Chronic Disease Management	Covered [16]	
Chemotherapy	90%	50% [14]
Chiropractic (20 visits max per year)	$15 Copay (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$10 Copay	Not Covered

Platinum PPO

Groups Beginning 1.1.2026

Services	PPO B	
Participating Health Plans	Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group	
Metal Tier	**Platinum**	
	In-Network	Out-of-Network [9]
Physical, Occupational, Speech Therapy	$10 Copay	50% [14]
Rehabilitative & Habilitative Services and Devices	$10 Copay [11]	50% [11]
Home Health Care (Max 100 visits per year)	90% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit)(Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	90% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%	
Mental Health		
In-Patient	90%	50% (up to $650 per day) [5]
Out-Patient (office visit)	$10 Copay	50%
Drug/Substance Abuse		
In-Patient (Detox Only)	90%	50% (up to $650 per day) [5]
Infertility		
Infertility Evaluation and Treatment	$10 Copay [7]	50% [7]
Infertility Drugs	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered
Pediatric Vision		
Carrier	Anthem Vision	Anthem Vision
Network	Blue View Vision	$0 Copayment plus any charges in excess of maximum allowed amount (ded waived)
Exam	100%	
Contact Lenses	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of maximum allowed amount (ded waived)
Frames	100% (1 per calendar year)	$0 Copayment plus any charges in excess of maximum allowed amount (ded waived)
Maximum Allowance per year	1 per calendar year	1 per calendar year
Pediatric Dental		
Carrier	Anthem Dental	Anthem Dental
Network	Prime	
Deductible	None	None
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%
Diagnostic &Preventative (D&P)	100%	100%
Basic Services	80%	80%
Major Services (no waiting period)	50%	50%
Orthodontics (medically necessary)	50%	50%

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

(Footnotes continued on page 24)

Additional Footnotes

Groups Beginning 1.1.2026

Platinum PPO

(Footnotes continued from page 23)

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

1. Family Out-of-Pocket Limit: For any given Member, the Out-of-Pocket Limit is met either after he/she meets their individual Out-of-Pocket Limit, or after the entire family Out-of-Pocket Limit is met. The family Out-of-Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out-of-Pocket Limit toward the family Out-of-Pocket Limit.
2. The four prescription drug tiers are: tier 1 typically generic drugs and low-cost preferred brand name drugs; tier 2 typically non-preferred generic drugs, preferred brand name drugs; tier 3 typically non-preferred brand name drugs; and tier 4 typically drugs that are biologics or distributed through a specialty pharmacy. Plans use the RxChoice Tiered Network, which includes a choice of two levels of copays -- the first copay listed is for Level 1 pharmacies and the second copay listed is for Level 2.
3. See plan specific EOC for information on preventive services.
4. Coverage for Home Health and Private Duty Nursing combined is limited to 100 4 hour visits per benefit period, in-network and out-of-network providers combined.
5. Amount listed is maximum paid by Anthem.
6. Classified specialty drugs must be obtained through Anthem's Specialty Pharmacy Program and are subject to the terms of the program.
7. Evaluation only.
8. Maximum member responsibility.
9. When you use an out-of-network provider, you will have higher cost sharing amounts to pay. Anthem's payment is based on a maximum allowed amount (includes certain benefits with maximum payment limits) and an out-of-network provider can charge you for amounts in excess of the Maximum Allowed Amount (there is an exception for Emergency Care received in California). In addition, only the maximum allowed amount for out of network services is applied towards your Out-of-Network deductible and out of pocket.
10. Manipulation Therapy only: benefit maximum of 20 visits per benefit period, office and outpatient visits combined.
11. Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.
12. Coverage for inpatient rehabilitation and skilled nursing services combined is limited to 100 days per skilled nursing facility benefit period (not per disability).
13. Medical emergency only.
14. Cost share varies depending on place of service, see plan specific EOC for cost shares of other settings.
15. Dr. Visits (PCP)/ Specialist Visit (SPC). $0 Copay for virtual visits through online provider – LiveHealth Online.
16. The following services are covered in full with deductible waived when member is diagnosed with the corresponding chronic condition: Blood pressure monitor for hypertension; Retinopathy screening for diabetes; Peak flow monitor for asthma; Glucometer for diabetes; Hemoglobin A1C testing for diabetes; International Normalized Ratio (INR) testing for liver disease and/or bleeding disorders. In addition, Anthem offers dedicated support through programs that help members manage specific medical conditions successfully.
17. 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.

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