BENEFIT SUMMARIES

CaliforniaChoice®
Your Health. Your Choice.®

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 1.1.2026

Bronze

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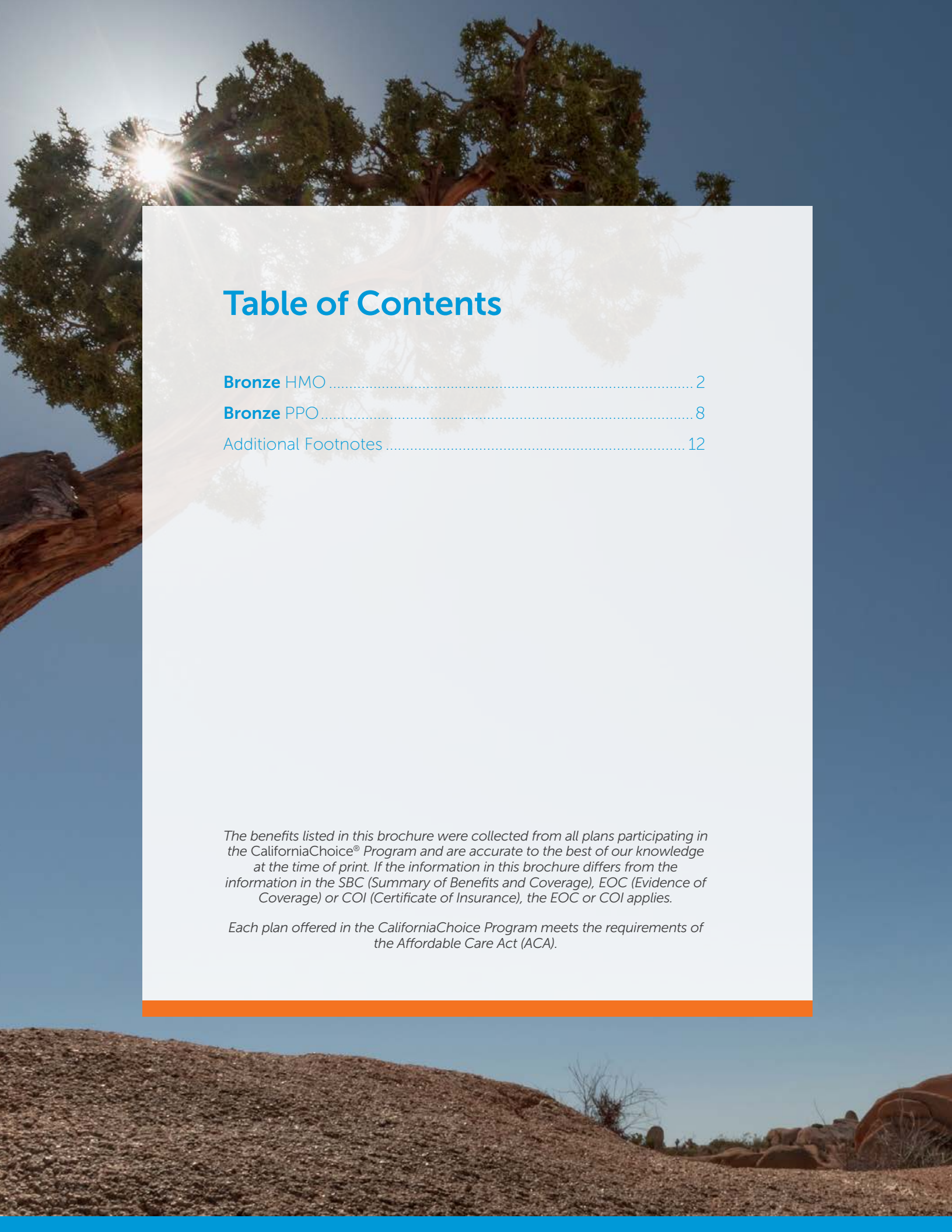
Knowledge Management & Learning Specialist
*and **CaliforniaChoice**® Member*

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).

Bronze HMO

Groups Beginning 1.1.2026

Services	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 [17] (applies to Max OOP)	$7,200 / $14,400 [17] (combined Med/Rx ded) (applies to Max OOP)	$7,600 / $15,200 [1] (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$9,800 / $19,600 [2]	$7,200 / $14,400 [2]	$8,500 / $17,000 [1, 11]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	100%	$55 Copay
Specialist Visit (SPC)	$95 Copay [20]	100%	$55 Copay
Laboratory	$50 Copay (ded waived)	100%	$15 Copay
X-Ray	60%	100%	$55 Copay
MRI, CT and PET (office setting)	60% per procedure	100% per procedure	$175 Copay
Virtual/Telemedicine Office Visit	100% (ded waived)	100%	Covered as any Illness
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
Urgent Care	$60 Copay (ded waived)	100%	$55 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 100% 100%	 60% 60%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$95 Copay [20]	100%	$55 Copay
Ambulance Services (per trip)	60%	100%	$500 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $450 / $900 Ded – 60% (up to $500 per prescription [6]) $450 / $900 Ded – 60% (up to $500 per prescription [6]) (with physician approval) $450 / $900 Ded – 60% (up to $500 per prescription [6]) (with physician approval)	 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) 100% (combined Med/Rx ded) (with physician approval) 100% (combined Med/Rx ded) (with physician approval)	 $20 Copay (overall ded waived) $60 Copay (overall ded waived) $100 Copay (overall ded waived) 60% (up to $500 per prescription [6]) (overall ded waived)
Oral Contraceptives	100% (ded waived)	100% (ded waived)	100% (if in formulary)
Diabetes – Self-Injectable	$450 / $900 Ded – 60% (up to $500 per prescription [6])	100% (combined Med/Rx ded)	Applicable Rx Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	$800 Copay per day – 3 days max [9]
Preventive/Wellness Services	100% (ded waived) [4]	100% (ded waived) [4]	100% (ded waived) [4]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	$55 Copay
Chemotherapy	60%	100%	Variable [5]
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$60 Copay (ded waived)	100%	$55 Copay
Physical, Occupational, Speech Therapy	$60 Copay (ded waived)	100%	$55 Copay
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived)	100%	$55 Copay

Bronze HMO

Groups Beginning 1.1.2026

Services	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**
Home Health Care (Max 100 visits per year)	60% [10]	100% [10]	$55 Copay
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	100%	$25 Copay per day
Hospice (out-patient)	100% (ded waived)	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	60% [19, 21]	100% [19, 21]	50%
Mental Health			
In-Patient	60%	100%	$125 Copay per day – 3 days max
Out-Patient (office visit)	100% (ded waived)	100%	$55 Copay
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	100%	$125 Copay per day – 3 days max
Infertility			
Infertility Evaluation and Treatment	Not Covered	Not Covered	Not Covered
Infertility Drugs	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered
Pediatric Vision			
Carrier	Kaiser Permanente	Kaiser Permanente	VSP
Network	Kaiser Permanente	Kaiser Permanente	VSP Advantage Network
Exam	100% (ded waived)	100% (ded waived)	100%
Contact Lenses	1 pair per calendar year [12]	1 pair per calendar year [12]	1 pair in lieu of eyeglasses
Frames	1 pair per calendar year (ded waived) [12]	1 pair per calendar year (ded waived) [12]	100% (Pediatric Exchange collection only)
Maximum Allowance per year	None	None	None
Pediatric Dental			
Carrier	Delta Dental	Delta Dental	Delta Dental of California
Network	DeltaCare USA	DeltaCare USA	Delta Dental DeltaCare USA
Deductible	None	None	None
Out-of-Pocket Maximum	$350 / $700	$350 / $700	Combined with Medical
Office Visit	100% (ded waived)	100% (ded waived)	100% [3]
Diagnostic & Preventative (D&P)	100% (ded waived)	100% (ded waived)	100% [14]
Basic Services	$95 Copay [7]	$95 Copay [7]	$25 Copay [15]
Major Services (no waiting period)	$365 Copay [8]	$365 Copay [8]	$300 Copay [16]
Orthodontics (medically necessary)	$350 Copay	$350 Copay	$1,000 Copay [13]

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

† HSA Qualified High Deductible Plan

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

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

Bronze HMO

Groups Beginning 1.1.2026

Services	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 [1] (applies to Max OOP)	$7,200 / $14,400 [1] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,250 / $14,500 [10, 17]	$9,800 / $19,600 [2]	$7,200 / $14,400 [2]
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	60%	$60 Copay (ded waived) [9]	100% [9]
Specialist Visit (SPC)	60%	$95 Copay [8]	100%
Laboratory	60%	$50 Copay (ded waived)	100%
X-Ray	60%	60%	100%
MRI, CT and PET (office setting)	60%	60%	100%
Virtual/Telemedicine Office Visit	Covered as any Illness	Variable [4]	Variable [4]
Hospital Services – In-Patient	60%	60%	100%
In-Patient Physician Fees	60%	60%	100%
Emergency Room (copay waived if admitted)	60%	60%	100%
Urgent Care	60%	$60 Copay (ded waived)	100%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% 60%	 60% 60%	 100% 100%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	60%	$95 Copay [8]	100%
Ambulance Services (per trip)	60%	60%	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded) 60% (up to $500 per prescription [15]) (combined Med/Rx ded)	 $20 Copay (ded waived) [3] $450 / $900 Ded – 60% (up to $500 per prescription [15]) [3] $450 / $900 Ded – 60% (up to $500 per prescription [15]) [3] $450 / $900 Ded – 60% (up to $500 per prescription [15]) [3]	 100% (combined Med/Rx ded) [3] 100% (combined Med/Rx ded) [3] 100% (combined Med/Rx ded) [3] 100% (combined Med/Rx ded) [3]
Oral Contraceptives	100% (if in formulary)	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (combined Med/Rx ded)	$450 / $900 Ded – Applicable Rx Copay [3]	Applicable Rx Copay (combined Med/Rx ded) [3]
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	60% [20]	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [5]	100% (ded waived) [5]	100% (ded waived) [5]
Chronic Disease Management	60%	Covered as any Illness	Covered as any Illness
Chemotherapy	Variable [11]	60%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	60%	$60 Copay (ded waived)	100%
Physical, Occupational, Speech Therapy	60%	$60 Copay (ded waived)	100%
Rehabilitative & Habilitative Services and Devices	60%	$60 Copay (ded waived)	100%

Bronze HMO

Groups Beginning 1.1.2026

Services	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**
Home Health Care (Max 100 visits per year)	60%	60%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	60%	60%	100%
Hospice (out-patient)	100%	100% (ded waived)	100%
Durable Medical Equipment (Covered when medically necessary)	50%	60%	100%
Mental Health			
In-Patient	60%	60% [16]	100% [16]
Out-Patient (office visit)	60%	$60 Copay (ded waived)	100%
Drug/Substance Abuse			
In-Patient (Detox Only)	60%	60% [16]	100% [16]
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	Choice Network	Choice Network
Exam	100%	100% (ded waived) [6]	100% (ded waived) [6]
Contact Lenses	1 pair in lieu of eyeglasses	100% (in lieu of eyeglasses) (ded waived) [6, 7]	100% (in lieu of eyeglasses) (ded waived) [6, 7]
Frames	100% (Pediatric Exchange collection only)	100% (in lieu of contact lenses) (ded waived) [6, 7]	100% (in lieu of contact lenses) (ded waived) [6, 7]
Maximum Allowance per year	None	1 pair per year	1 pair per year
Pediatric Dental			
Carrier	Delta Dental of California	Delta Dental	Delta Dental
Network	Delta Dental 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% [14]	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Diagnostic & Preventative (D&P)	100% [18]	100% (ded waived)	100% (ded waived)
Basic Services	$25 Copay [12]	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Major Services (no waiting period)	$300 Copay [13]	Copay varies by service (ded waived)	Copay varies by service (ded waived)
Orthodontics (medically necessary)	$1,000 Copay [19]	$1,000 Copay (ded waived)	$1,000 Copay (ded waived)

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

† HSA Qualified High Deductible Plan

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

1. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health 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 $3,400 for 2026 plans.
2. Member cost sharing payments for all essential health benefits (EHBs) accumulate toward the OOPM. This includes cost sharing that accumulates toward an applicable deductible. This does not include cost sharing for most optional benefits.
3. Cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100-day supply is available, at twice the 30-day retail copayment price, through the mail-order pharmacy. Specialty drugs are available for up to a 30-day supply through the specialty pharmacy. Cost sharing for a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when applicable, will be 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.
4. Cost share for telehealth is the same as the in-person visit, please refer to the specific in-person service amount.
5. See plan specific EOC for information on preventive services.
6. Pediatric eye exam and glasses or contact lenses are provided annually for members under age 19 as part of the essential health benefit for pediatric vision.
7. A complete pair of glasses or standard contact lenses, in lieu of glasses, are covered every calendar year.
8. When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non-preventive visits", the deductible is waived for the first three non-preventive visits combined.

(Footnotes continued on page 12)

Bronze HMO

Groups Beginning 1.1.2026

Services	HMO B	HMO C† HSA Qualified
Participating Health Plans	Western Health Advantage	Western Health Advantage
Network Name	Full	Full
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$5,800 / $11,600 [1, 7] (applies to Max OOP)	$7,200 / $14,400 [1, 7] (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$9,800 / $19,600 [2, 7]	$7,200 / $14,400 [2, 7]
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$60 Copay (ded waived)	100% [1]
Specialist Visit (SPC)	$95 Copay [9]	100% [1]
Laboratory	$50 Copay (ded waived)	100% [1]
X-Ray	60% [1, 4]	100% [1]
MRI, CT and PET (office setting)	60% [1, 4]	100% [1]
Virtual/Telemedicine Office Visit	Variable [13]	Variable [13]
Hospital Services – In-Patient	60% [1, 4]	100% [1]
In-Patient Physician Fees	60% [1, 4]	100% [1]
Emergency Room (copay waived if admitted)	60% [1, 4]	100% [1]
Urgent Care	$60 Copay (ded waived)	100% [1]
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 60% [1, 4] 60% [1, 4]	 100% [1] 100% [1]
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$95 Copay [9]	100% [1]
Ambulance Services (per trip)	60% [1, 4]	100% [1]
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $20 Copay (ded waived) $450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4, 11] $450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4, 11] $450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4]	 100% (combined Med/Rx ded) [1] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1, 11] 100% (combined Med/Rx ded) [1]
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	$450 / $900 Ded – 60% (up to $500 per 30 day supply [8]) [1, 4]	100% (combined Med/Rx ded) [1]
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [3, 6]	100% (ded waived) [3, 6]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	60% [1, 4]	100% [1]
Chiropractic (20 visits max per year)	Not Covered	100% [1, 12]
Acupuncture	$60 Copay (ded waived)	100% [1]
Physical, Occupational, Speech Therapy	$60 Copay (ded waived)	100% [1]
Rehabilitative & Habilitative Services and Devices	$60 Copay (ded waived)	100% [1]

Bronze HMO

Groups Beginning 1.1.2026

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

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

† HSA Qualified High Deductible Plan

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

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are rendered until the deductible is met in that calendar year. Charges under the deductible are based on WHA's contracted rates with the provider of service.
2. The annual out-of-pocket maximum is the total amount the member must pay for certain services in a calendar year.
3. There may be an office visit copay if the primary purpose of a visit is not preventive or other services are provided.
4. Percentage copayment amounts are based on WHA's contracted rates with the provider of service or medication.
5. See copayment summary for applicable prosthetic/orthotic device copayment amount.
6. See plan specific EOC for information on preventive services.
7. The deductible and annual out-of-pocket maximum amounts are embedded, i.e. each member in the family must meet the individual amount or the family must meet the family amount before benefits will apply for that member.
8. Maximum member responsibility.
9. The deductible is waived for first three combined visits for non-preventive specialty care visits.
10. 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.
11. 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.
12. Copayments do not contribute to out-of-pocket maximum.
13. Cost share amount varies based on type of services rendered.

Bronze PPO

Groups Beginning 1.1.2026

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$6,250 / $12,500 (combined Med/Rx ded) (applies to Max OOP)	$12,500 / $25,000 (combined Med/Rx ded) (applies to Max OOP)	$6,250 / $12,500 (combined Med/Rx ded) (applies to Max OOP)	$12,500 / $25,000 (combined Med/Rx ded) (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$7,350 / $14,700 [1]	$14,700 / $29,400 [1]	$7,350 / $14,700 [1]	$14,700 / $29,400 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	65%	50%	65%	50%
Specialist Visit (SPC)	65%	50%	65%	50%
Laboratory	65%	50%	65%	50%
X-Ray	65%	50%	65%	50%
MRI, CT and PET (office setting)	65%	50% (up to $800 per test) [5]	65%	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	65% / 65% [15]	50%	65% / 65% [15]	50%
Hospital Services –In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
In-Patient Physician Fees	65%	50%	65%	50%
Emergency Room (copay waived if admitted)	65%		65%	
Urgent Care	65%	50%	65%	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit - 65% $50 Copay per admit - 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit - 65% $50 Copay per admit - 65%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	65%	50%	65%	50%
Ambulance Services (per trip)	65% [13]		65% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $20 Copay / Level 2 $20 Copay (combined Med/Rx ded) [2, 17] Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx ded) [2, 17] Level 1 $160 Copay / Level 2 $170 Copay (combined Med/Rx ded) [2] Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (combined Med/Rx ded) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered	 Level 1 $20 Copay / Level 2 $20 Copay (combined Med/Rx ded) [2, 17] Level 1 $90 Copay / Level 2 $100 Copay (combined Med/Rx ded) [2, 17] Level 1 $160 Copay / Level 2 $170 Copay (combined Med/Rx ded) [2] Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (combined Med/Rx ded) (prior auth. required) [2, 6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2, 17]	Not Covered	Applicable Ded / Rx Copay [2, 17]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered [16]		Covered [16]	
Chemotherapy	65%	50% [14]	65%	50% [14]
Chiropractic (20 visits max per year)	50% (20 visits max per benefit period) [10]	Not Covered	50% (20 visits max per benefit period) [10]	Not Covered

Bronze PPO

Groups Beginning 1.1.2026

Services	PPO A † HSA Qualified		PPO B † HSA Qualified	
Participating Health Plans	Anthem Blue Cross		Anthem Blue Cross	
Network Name	Prudent Buyer – Small Group		Select PPO	
Metal Tier	**Bronze**		**Bronze**	
	In-Network	Out-of-Network [9]	In-Network	Out-of-Network [9]
Acupuncture	65%	Not Covered	65%	Not Covered
Physical, Occupational, Speech Therapy	65%	50% [14]	65%	50% [14]
Rehabilitative & Habilitative Services and Devices	65% [11]	50% [11]	65% [11]	50% [11]
Home Health Care (Max 100 visits per year)	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	65% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	65% [12]	50% (up to $150 per day) [5, 12]	65% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health				
In-Patient	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
Out-Patient (office visit)	65%	50%	65%	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	65%	50% (up to $650 per day) [5]	65%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	65% [7]	50% [7]	65% [7]	50% [7]
Infertility Drugs	Not Covered	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision				
Carrier	Anthem Vision	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision		Blue View Vision	
Exam	100% (ded waived)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	100% (ded waived)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Contact Lenses	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (in lieu of eyeglasses)
Frames	100% (ded waived) (1 per calendar year)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)	100% (ded waived) (1 per calendar year)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental				
Carrier	Anthem Dental	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime		Prime	
Deductible	None	None	None	None
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

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

(Footnotes continued on page 12)

Bronze PPO

Groups Beginning 1.1.2026

Services	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 [9]	In-Network	Out-of-Network [9]
Calendar Year Deductible*	$6,000 / $12,000 (applies to Max OOP)	$12,000 / $24,000 (applies to Max OOP)	$6,000 / $12,000 (applies to Max OOP)	$12,000 / $24,000 (applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$8,500 / $17,000 [1]	$17,000 / $34,000 [1]	$8,500 / $17,000 [1]	$17,000 / $34,000 [1]
Lifetime Maximum	Unlimited		Unlimited	
Dr. Office Visits (PCP)	$65 Copay	50%	$65Copay	50%
Specialist Visit (SPC)	$85 Copay	50%	$85 Copay	50%
Laboratory	60%	50%	60%	50%
X-Ray	60%	50%	60%	50%
MRI, CT and PET (office setting)	60% [14]	50% (up to $800 per test) [5]	60% [14]	50% (up to $800 per test) [5]
Virtual/Telemedicine Office Visit	$65 Copay / $85 Copay [15]	50%	$65 Copay / $85 Copay [15]	50%
Hospital Services –In-Patient	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
In-Patient Physician Fees	60%	50%	60%	50%
Emergency Room (copay waived if admitted)	$250 Copay – 60%		$250 Copay – 60%	
Urgent Care	$65 Copay	50%	$65 Copay	50%
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $250 Copay per admit - 60% $50 Copay per admit - 60%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]	 $250 Copay per admit - 60% $50 Copay per admit - 60%	 50% (up to $380 per admit) [5] 50% (up to $380 per admit) [5]
Hospital Pre-Authorization	Not Required		Not Required	
2nd Surgical Opinion	$85 Copay	50%	$85 Copay	50%
Ambulance Services (per trip)	60% [13]		60% [13]	
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 Level 1 $20 Copay / Level 2 $20 Copay (ded waived) [2] $650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay [2] $650 / $1,300 Ded - Level 1 $160 Copay / Level 2 $170 Copay [2] $650 / $1,300 Ded - Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (prior auth. required) [2,6]	 Not Covered Not Covered Not Covered]Not Covered	 Level 1 $20 Copay / Level 2 $20 Copay (ded waived) [2] $650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay [2] $650 / $1,300 Ded - Level 1 $160 Copay / Level 2 $170 Copay [2] $650 / $1,300 Ded - Level 1 70% (up to $400 per prescription [8]) / Level 2 60% (up to $500 per prescription [8]) (prior auth. required) [2,6]	 Not Covered Not Covered Not Covered Not Covered
Oral Contraceptives	100%	Not Covered	100%	Not Covered
Diabetes – Self-Injectable	Applicable Ded / Rx Copay [2]	Not Covered	Applicable Ded / Rx Copay [2]	Not Covered
Pre-Existing Conditions	Covered		Covered	
Maternity and Newborn Care	Covered as any Illness		Covered as any Illness	
Preventive/Wellness Services	100% (ded waived) [3]	50% [3]	100% (ded waived) [3]	50% [3]
Chronic Disease Management	Covered [16]		Covered [16]	
Chemotherapy	60%	50% [14]	60%	50% [14]
Chiropractic (20 visits max per year)	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered	$15 Copay (ded waived) (20 visits max per benefit period) [10]	Not Covered
Acupuncture	$65 Copay	Not Covered	$65 Copay	Not Covered

Bronze PPO

Groups Beginning 1.1.2026

Services	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 [9]	In-Network	Out-of-Network [9]
Physical, Occupational, Speech Therapy	60%	50% [14]	60%	50% [14]
Rehabilitative & Habilitative Services and Devices	60% [11]	50% [11]	60% [11]	50% [11]
Home Health Care (Max 100 visits per year)	60% (Max 100 visits per benefit period) [4]	50% (up to $75 per visit) (Max 100 visits per benefit period) [4, 5]	60% (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)	60% [12]	50% (up to $150 per day) [5, 12]	60% [12]	50% (up to $150 per day) [5, 12]
Hospice (out-patient)	100%	50%	100%	50%
Durable Medical Equipment (Covered when medically necessary)	50%		50%	
Mental Health				
In-Patient	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
Out-Patient (office visit)	60%	50%	60%	50%
Drug/Substance Abuse				
In-Patient (Detox Only)	60%	50% (up to $650 per day) [5]	60%	50% (up to $650 per day) [5]
Infertility				
Infertility Evaluation and Treatment	$65 Copay [7]	50% [7]	$65 Copay [7]	50% [7]
Infertility Drugs	Not Covered	Not Covered	Not Covered	Not Covered
In Vitro Fertilization (IVF)	Not Covered	Not Covered	Not Covered	Not Covered
Gamete Intrafallopian Transfer (GIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Zygote Intrafallopian Transfer (ZIFT)	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision				
Carrier	Anthem Vision	Anthem Vision	Anthem Vision	Anthem Vision
Network	Blue View Vision		Blue View Vision	
Exam	100% (ded waived)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	100% (ded waived)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Contact Lenses	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)	100% (in lieu of eyeglasses)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived)
Frames	100% (ded waived) (1 per calendar year)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)	100% (ded waived) (1 per calendar year)	$0 Copayment plus any charges in excess of the maximum allowed amount (ded waived) (1 per calendar year)
Maximum Allowance per year	1 per calendar year	1 per calendar year	1 per calendar year	1 per calendar year
Pediatric Dental				
Carrier	Anthem Dental	Anthem Dental	Anthem Dental	Anthem Dental
Network	Prime		Prime	
Deductible	None	None	None	None
Out-of-Pocket Maximum	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)	Combined with Medical (IN & OON)
Office Visit	100%	100%	100%	100%
Diagnostic & Preventative (D&P)	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services (no waiting period)	50%	50%	50%	50%
Orthodontics (medically necessary)	50%	50%	50%	50%

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

(Footnotes continued on page 12)

Additional Footnotes

Groups Beginning 1.1.2026

Bronze HMO

(Footnotes continued from page 5)

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

Bronze PPO

(Footnotes continued from page 9)

† HSA Qualified High Deductible Plan

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

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

(continued in next column)

Bronze PPO - *continued*

(Footnotes continued from page 9)

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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Bronze PPO

(Footnotes continued from page 11)

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

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

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