CALAVERAS CONSOLIDATED FIRE PROTECTION DISTRICT
6501 Jenny Lind Road, Valley Springs, CA 95252
Telephone: (209) 786-2227
www.calcofire.org

Special Meeting Agenda
December 18, 2023

1. **CALL TO ORDER 6:00PM**

2. **PLEDGE OF ALLEGIANCE**

3. **MOMENT OF SILENCE:** To recognize and honor the efforts of the American Service Member and Public Safety Personnel

4. **ROLL CALL:** Board Members: Keith Hafley, Sam Harris, Ryan Hamre, Pat Sullivan, Ken Glissman, Chris Allen, Tim Runion, and Garrett Robertshaw

   Staff: Fire Chief Rich Dickinson and Rose Beristianos

5. **ELECTION OF 2024 BOARD CHAIR**
6. **ELECTION OF 2024 VICE CHAIR**
7. **ELECTION OF BOARD CLERK**
8. **ELECTION OF COMMITTEES – PERSONNEL AND FINANCE**

9. **PUBLIC COMMENT:** The public may address the Board on any item of interest that is not on the agenda and is within the District's jurisdiction. For items that are on the agenda, public comment will be heard when the item is discussed. The Chairman reserves the right to limit each speaker to three (3) minutes per person and 15 minutes per topic. Ralph M Brown Act Gov. (Code, § 54954.3(b).) By law, the Board of Directors cannot make decisions on matters not on the agenda. Ralph M Brown Act Gov. (Code, § 54954.2(a).)

10. **CONSENT CALENDAR**: The Consent Calendar includes routine financial and administrative actions and is usually approved by a single majority vote. There will be no discussion on these items prior to voting on the motion unless Board Members, the public or staff request specific items be discussed and/or removed from the Consent Calendar.

    A. Approval of Draft Minutes: November 6, 2023, Special Meeting

11. FINANCE BUSINESS

A. Supplemental Transmittals – Due to the Calcard Statement, Regular Bills and Calcard Payments will be added as a supplemental.

12. FIRE CHIEF'S REPORT

13. CORRESPONDENCE:

14. UNFINISHED BUSINESS: Since this Old Business has been discussed in prior meetings, the Chairman reserves the right to limit each speaker to three (3) minutes per person per topic. Ralph M. Brown Act Gov. (Code, § 54954.3(b).

A. Discussion/Action –

15. NEW BUSINESS:

A. Discussion/Action – Credit Card Purchasing and Purchase Orders
B. Discussion/Action – Training Structure Proposal
C. Discussion/Action - Strategic Plan Update from Committee, for Board Approval
D. Discussion/Action – Cordico Proposal
E. Discussion/Action – Medical Insurance

16. COMMITTEE COMMENTS

17. BOARD OF DIRECTOR AND FIRE CHIEF COMMENTS

18. ADJOURNMENT:

Next Meeting Scheduled for January 22, 2024

CALAVERAS CONSOLIDATED FIRE PROTECTION DISTRICT
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Regular Meeting Draft Minutes
November 27, 2023

1. CALL TO ORDER 6:00PM
2. ROLL CALL: **Board Members Present**: Keith Hafley, Sam Harris, Ryan Hamre, Ken Glissman, Chris Allen,Tim Runion, and Garrett Robertshaw

   Board Members Absent: Pat Sullivan, Chris Damin

   Staff Present: Fire Chief Rich Dickinson and Rose Beristianos
3. PLEDGE OF ALLEGIANCE
4. MOMENT OF SILENCE: To recognize and honor the efforts of the American Service Member and Public Safety Personnel.
5. PUBLIC COMMENT: **Francisco DeLa Cruz spoke about the Next Door activity that is closed minded regarding Tax Measure**
   Mike Rodgers spoke about Measure A
6. CONSENT CALENDAR**: Item C pulled by Tim Runion, Moition to approve A and B by Sam Harris, Seconded by Ken Glissman, passed 7 yes.**
   Discussion on item C regarding receipts and options, motion to approve item C by Tim Runion, seconded by Chris Allen, passed 7 yes
   A. Approval of Draft Minutes: November 6, 2023, Special Meeting
   B. Approval of Regular Bills Transmittal OH178437, $4,815.04
   C. Approval of CalCard Transmittal OH178437, $13,182.18
7. FINANCE BUSINESS
   A. Supplemental Transmittals**: OH178442, Randy Echols payment, Journal Entry for payment to San Andreas for trailer. Motion to approval all by Ken Glissman, seconded by Sam Harris, passed 7 Yes**
8. FIRE CHIEF'S REPORT - **Chief gave his report**

9. CORRESPONDENCE: **Chris Damin Resignation Letter received November 26, 2023**

10. UNFINISHED BUSINESS: **None**

11. NEW BUSINESS:

A. Discussion/Action – Strategic Plan Update from Committee, for Board Approval, **Mike Rodgers spoke about the current strategic plan and how they are still working on it and will bring it back for board approval**.

12. COMMITTEE COMMENTS - **None**

13. CLOSED SESSION: **Discussion on if board can keep a closed session item on the agenda, Rose to reach out to Tim Talbot**

14. BOARD OF DIRECTOR AND FIRE CHIEF COMMENTS – **Round table comments**

15. ADJOURNMENT: **Motion to adjourn the meeting at 7:22pm by Tim Runion, seconded by Garrett Robershaw**

ARTICLE: F

SECTION: 1

DATE REVISED: 1-25-16

SUBJECT: Fiscal Management: Purchasing

POLICY:

The Calaveras Consolidated Fire District is committed to being good stewards of the funds entrusted to the District by the taxpayers and citizens of the District. The Calaveras Consolidated Fire District will exercise its fiduciary obligations in a forthright, open, and transparent manner, ensuring the accountability of all employees and members.

PURPOSE:

Purchasing of goods and services should be conducted in manner that efficiently assures that the District is receiving quality goods and services, while at the same time reduces or eliminates the potential for fraud, embezzlement, misuse, or abuse of the District's financial resources.

PROCEDURE:

A: PURCHASE ORDERS

1. All goods and services purchased must have an approved Purchase Order completed prior to the purchase.
2. Any order or invoice without an approved Purchase Order will not normally be paid.
3. The Purchase Order is to be completed prior to the order being placed.
4. Purchase Orders must include the vendor's name and address, amount of the purchase or a good faith estimate of the amount of the purchase, and a description of the item(s).
5. If freight is included, the amount, or an estimate, must be included separately on the Purchase Order.

B: AUTHORIZED PURCHASES

1. The Fire Chief and the Administrative Assistant may authorize purchases up to and including $5,000 per item.
2. Purchases exceeding $5,000 per item require prior approval of the Board of Directors.
3. In the event of an emergency where insufficient time is available to obtain the required approval the Fire Chief is authorized to approve the purchase. In this case the Fire Chief will notify the President as soon as practical of the purchase and the nature of the emergency resulting in the lack of prior approval for the purchase

Training Structure proposal

1 message

Hi Ryan,

I was able to reduce our fee as outlined below:

PHASE I: CONCEPTUAL DESIGN DRAWINGS:
I will not bill for any of my time.
Original Fee: $1,500.00 Proposed Fee: $0.00
Savings: $1,500.00

PHASE II: CONSTRUCTION DOCUMENTS:
I will lower our rate from $165.00/hr. to $125.00/hr.
I've eliminated 3 hours from this fee associated with administration.
Original fee; $13,700.00 Proposed Fee $10,000.00
Saving: $3,700.00

TOTAL ARCHITECTURAL FEE FOR THE PROJECT: $10,000.00.

Total saving for Architectural services: $5,200.00

The $10,000.00 pays for my guys time, associated payroll taxes and benefits most of the other associated overhead, and eliminates any profit associated with the architectural portion of the project. It does not include any construction cost required to build out the project.

I spoke to my structural engineer. He reminded me that he always gives me his best fees, and was not able to lower his fee. His fee remains at $6,860.00.

If this will work for you, let me know and I will revise our proposal to reflect the reduced fees.

Thank you,

Randall Harris
HDO Architects-Planners
2950 Camino Diablo, Suite 110
Walnut Creek, CA 94597
(925) 256-6042 x-16

A Cost-Effective Solution for Public Safety Wellness

Law enforcement officers, firefighters, dispatchers and other public safety personnel are tasked with handling the most high-risk, urgent and dangerous events in our communities. They respond routinely to incidents most people never experience firsthand—suicides, murders, accidents, natural disasters, violence committed against children, sexual offenses, violent individuals, noncompliant suspects, people in the throes of crisis. The job carries the constant potential for injury and risk to safety and security.

Public safety and local government leaders and elected officials have a great opportunity to support the wellness of the first responders we trust to provide the most urgent, critical and high-stakes service to the community. The key lies in delivering confidential, immediately accessible resources that are customized for the issues first responders face.

Fortunately, doing just that is not only possible, it's surprisingly cost-effective.

Public Safety Wellness Challenges

First responders pay a price for their dedication to their profession. They experience high rates of suicidal ideation, post-traumatic stress and depression; in nationwide surveys, firefighters and officers overwhelmingly report stress on the job has impacted their mental health.[1,2,3]

The effects are physical, too; 70% of firefighters are obese or overweight; 40% of police officers are obese and 80% are overweight.[4,5] Complications from shift work compound the issues: Nearly 40% of firefighters screen positive for sleep disorders,[6] while fatigue has been shown to affect police officer decision making and judgment.[7]

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[1]Ushery D, Manny D, Stulberger E. (11/20/18). Nearly 1 in 5 cops has considered suicide amid stigma around mental health issues. https://www.nbcnewyork.com/news/local/i-team-nearly-1-in-5-cops-has-considered-suicide-amid-stigma-around-mental-health-issues/1817436/

[2]Wagner E, Bott M, Villarreal M et al. (3/1/18) National data shows firefighters' mental, emotional health not getting enough attention. https://www.nbcbayarea.com/news/local/national-data-shows-firefighters-mental-emotional-health-not-getting-enough-attention/196910/

[3]Substance Abuse and Mental Health Services Administration. (May 2018) First Responders: Behavioral Health Concerns, Emergency Response, and Trauma. https://www.samhsa.gov/sites/default/files/dtac/supplementalresearchbulletin-firstresponders-may2018.pdf

[4]Wilkinson ML, Brown AL, Poston WS, et al. (2014) Physician Weight Recommendations for Overweight and Obese Firefighters, United States, 2011–2012. *Preventing Chronic Disease.* 11:140091. http://dx.doi.org/10.5888/pcd11.140091

[5]Can SH, Hendy H. (May 2014) Behavioral variables associated with obesity in police officers. *Industrial Health.* 52(3):240–247. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4209580

[6]Brigham and Women's Hospital. (11/13/14) Sleep disorders found to be highly prevalent in firefighters. *ScienceDaily.* https://www.sciencedaily.com/releases/2014/11/141113085220.htm

[7]James L. (9/21/17) The Stability of Implicit Racial Bias in Police Officers. *Police Quarterly.* 21(1)30–52. https://doi.org/10.1177/1098611117732974

While many municipalities and counties offer wellness services through an Employee Assistance Program, these are often inadequate for the unique stressors of a public safety career. First responders overwhelmingly report cultural stigmas that create a barrier to most seeking help for emotional and behavioral issues. And when they do seek help, 60% of officers and firefighters say the wellness resources provided to them through Employee Assistance Programs are not helpful.[1,2]

Hidden Costs of First Responder Mental Health Issues

Simply knowing that we are taking good care of our personnel—doing the right thing to support them—is motivation enough for most agency and local government leaders. But there also are strong qualitative reasons to proactively address first responder wellness.

In fact, there are five areas where your agency may be spending large sums of money related to first responder mental health without realizing it:

1. **Overtime costs** that rack up when personnel are out on sick leave or disability as a result of untreated mental health issues
2. **Worker's compensation** costs involving post-traumatic stress syndrome (many states now consider PTSD as presumptive for first responders)
3. **High healthcare costs** as a result of the physical impacts of stress, which can include cardiac issues, diabetes, obesity, substance abuse and sleep issues
4. **Costs associated with personnel complaints, lawsuits and settlements** that may be a result of poor decision-making by personnel suffering from lack of sleep, burnout or compassion fatigue
5. **Turnover costs**—including recruiting, training and equipping new personnel—when first responders choose to leave the agency due to chronic stress or feeling unsupported

As noted above, current support mechanisms for first responders are largely insufficient. Municipalities remain at significant financial risk if relying upon existing support resources.

The Wellness Solution for Public Safety: Cordico

Cordico's mobile wellness app provides a complete range of self-assessments as well as continuously updated videos and guides on more than 60 health and lifestyle management topics. This unique wellness solution meets three critical criteria necessary to overcome the stigma of asking for help and address the cumulative effects of chronic stress on first responders:

Confidential – First responders must have trust that they can access resources in a completely confidential manner that will not have an impact on their careers. Cordico's apps work through a generic link and generic password. There is no personal data tied to app (although we can provide aggregate data to help

leaders judge overall use or identify trends in resource usage).

Customized – Resources provided to first responders must reflect the realities of their jobs. Cordico's assessments, articles and videos are developed by first responder psychologists and are specifically tailored for public safety personnel. We also help agencies tailor their apps with agency-specific content or training and links to local resources.

Accessible – Public safety is a 24/7 business; first responders must be able to access resources quickly, easily and at any time of day. By delivering our content through an app, we provide one place for personnel to access all the wellness content the agency offers, available 24/7. Options include one-touch access to peer support and chaplains, teletherapy and a therapist finder.

The many benefits of implementing the Cordico app include:

- Demonstrating strong city/county support for the wellness of their first responders
- Providing in-hand, on-demand, easy access to a multitude of high-quality wellness tools and confidential resources specifically for public safety personnel
- Providing easier access to existing support mechanisms (e.g., peer support, therapists and local healthcare resources)
- Increasing utilization of a wide range of wellness support resources to promote a healthier workforce
- Improving recruitment, retention and morale and reducing absenteeism

Implementation of the Cordico apps has been associated with higher rates of utilization of support resources, the development of stronger wellness support options, and strong positive feedback regarding the program at all organizational levels.

Cordico Wellness App Investment

First responder wellness requires an investment, but the costs of the Cordico app are projected to be more than offset by savings in the form of improved employee wellness, lower employee stress, improved morale, decreased absenteeism and increased retention.

The annual subscription covers:

- App build, design, licensing, maintenance, technical support and ongoing updates (iPhone and Android)
- Unlimited use to all personnel employed by the agency
- Unlimited use at no cost to all spouses and significant others of personnel employed by the agency
- Unlimited use at no cost for all department retirees
- Implementation and support for promoting the app to agency personnel, including posters, QR codes for easy phone installation, and a customized PowerPoint presentation for shift briefings or roll call. These resources have resulted in a 90% app installation rate.

At the Forefront of Wellness

"If you do one thing for your agency this year, get this app. It will show that employee wellness is a priority, you truly care, and you want to make the best tools and resources accessible to your officers 24/7."

Kimberly A. Miller, Ph.D.
Police Psychologist, Consultant, Coach & Trainer
National Sheriffs' Association Member & Seminar Presenter

"The Cordico team provided exceptional customer service and went out of their way to make the development process smooth and fast. The finished product far exceeded my expectations and those of my command staff. We need our emergency responders to be at their peak performance levels, and the Cordico wellness app gives them the tools and resources to do just that."

Captain Eric Dayley
MA District Commander
Idaho State Police District Five

"I was looking for a way to inform our officers about the numerous resources that are available to support their emotional health and well-being. I also wanted to provide them with a roadmap to those resources. The Cordico wellness app is a confidential tool that hosts all of their wellness resources in one location, which allows our officers to have 24/7 access in the palm of their hands."

Lynnette Hall-Lewis, Esq., CWPC
Health Engagement Manager
City of Memphis

"With the Cordico app and the program we have in place, if something ever comes up for any of our members—even in retirement—they'll have immediate access to resources and somewhere to turn."

Fire Chief Brian Fennessy
Orange County (CA) Fire Authority

Ready to put *your* agency at the forefront of wellness? Request a demo today.

cordico.com/quote

sales@cordico.com

844-220-4929

Strengthen Your Wellness Culture **WITH TRAINING & CERTIFICATION**

Advanced Training For High-Stress Occupations

Personnel in public safety and other mission-critical occupations face daily physical, mental and emotional challenges. Peer support teams and mental health clinicians are vital in helping personnel prepare for and manage these challenges. But delivering effective, appropriate assistance requires specialized training and cultural competence.

Lexipol's Cordico wellness programs help peer support team members and clinicians understand and apply evidence-based practices for providing counseling and assistance. Backed by clinicians and subject matter experts specializing in public safety, our programs provide:

- The first national standardized certification for licensed clinicians interested in working with the public safety population
- Best practices, guidelines and research on peer support team efficacy
- Training on foundational and relevant topics, from critical incident response to relationship and family dynamics
- Resources to help personnel build and enhance sustained performance, wellness and resiliency
- Online courses, clinical tools and consultation

Ready to learn more? Scan to preview course listings, take a complimentary course and more!

APA APPROVED SPONSOR

APPROVED CONTINUING EDUCATION PROVIDER NBCC™

Peer Support Training & Certification

A well-trained and supervised peer support team can act as the first line of defense because personnel are more likely to trust colleagues they know have experienced similar challenges. Cordico peer support training and certification can boost your peer support team credibility and, even if you're just getting started, create a strong foundation for success. The program includes:

- 25 core hours of continuing education credit; numerous specialized and advanced courses
- Certified Peer Support Provider designation
- Advanced training through members-only interactive live webinars
- Consultation with subject matter experts
- Online Peer Support Toolkit with resources for starting and supporting your team

Clinician Training & Certification

Counseling those on the front lines of emergency response requires cultural competence and specialized training. Recognizing licensed clinicians of all levels for their advanced knowledge and commitment to supporting this unique population, our clinician training and certification includes:

- 40 hours of continuing education credit approved by the American Psychological Association (APA) and National Board for Certified Counselors (NBCC)
- Designation as an Emergency Responder and Public Safety Certified Clinician
- Advanced training through members-only interactive live webinars
- Consultation with subject matter experts
- Online clinical tools that enhance professional practice

Foundational, Relevant Training Topics

- Relationship & Family Dynamics
- Suicide Prevention, Intervention & Aftermath
- Post-Critical Incident & Trauma Support
- Moral Distress & Moral Injury
- Diversity Considerations & Clinical Insights
- Support Your Peer Through Grief & Loss
- Intervention Strategies & Peer Counseling
- Legal & Ethical Considerations
- Substance-Related Disorders & Addictions
- Reintegration Strategies
- ...& much more!

Join A Community Dedicated To Support

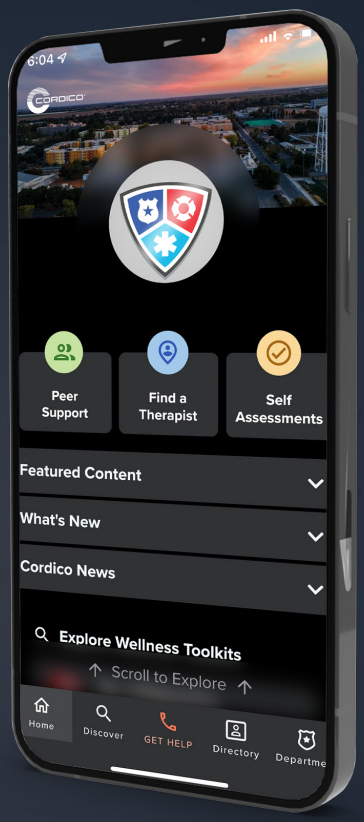
"This training is essential for new and seasoned clinicians alike who serve in any role on a peer support team with emergency responders. [It addresses] prevalent clinical issues facing peer support teams and how clinicians can help navigate them with ethics and boundaries."

Sarah Mildrum, LCSW
Guiding Light Counseling
Windham, ME

CORDICO®

WELLNESS THAT WORKS

Confidential, Anonymous Support for Your Firefighters



Fire and EMS professionals are exposed to potentially traumatic calls on nearly every shift. Nationwide, firefighters overwhelmingly report job-related stress has affected their mental health—yet more than 80% of firefighters say they fear being seen as weak or unfit for duty if they ask for help. Left unaddressed, stress can lead to self-destructive behaviors and leave firefighters unprepared to take care of community members.

Cordico's wellness solution addresses these challenges, providing firefighters and their family members with on-demand access to relevant, trusted and effective wellness resources—without collecting any personal information.

Our fire and rescue wellness app offers a complete range of self-assessments as well as continuously updated videos and guides on more than 60 behavioral health topics—all designed specifically to help first responders develop healthy habits, strengthen personal relationships and improve resilience.

When you deploy Cordico in your agency, you will:

- Connect your personnel to anonymous assessments and counseling resources
- Strengthen your wellness culture & empower your peer support team
- Support department retirees & family members (included with agency subscription)
- Go beyond crisis response with physical, mental & lifestyle management resources
- Help firefighters cope with the effects of critical events & chronic exposure
- Improve firefighter decision-making, empathy & resiliency, which in turn enhances customer service

Sourcewell
Awarded Contract
Contract #011822-LXP

Trusted, Tailored Behavioral Health Support

Cordico's wellness tools and self-assessments are designed to keep your personnel healthy and effective at work. Created by our clinical and scientific staff experienced in working with first responders, these resources are built for both prevention and treatment.

60+ Wellness Guides

- Substance Abuse
- Burnout
- Grief and Loss
- Family Support
- Financial Fitness
- Healthy Habits
- Posttraumatic Stress
- Suicide Prevention
- Fitness and Nutrition

Anonymous Self-Assessments

- Adult ADHD
- Alcohol Abuse
- Cordico Anger Scale
- Compassion Fatigue
- Posttraumatic Stress
- Resilience
- Cordico Sleep Test
- Perceived Stress
- Well-Being

AVAILABLE FEATURES

- Customized with your agency's badge and department resources
- Apple iOS and Android compatible
- Mobile one-touch calling to peer support
- Therapist finder
- Access to accredited wellness courses through Lexipol's FireRescue1 Academy

LEADERSHIP & WELLNESS WITH JOCKO WILLINK & LEIF BABIN

Lexipol is excited to partner with Echelon Front to provide an exclusive video series demonstrating how to use world-class leadership principles to build and sustain your agency's culture of wellness. Available only through the Cordico app!

ECHELON FRONT

Put Your Agency at the Forefront of Wellness

"With the Cordico app and the program we have in place, if something ever comes up for any of our members—even in retirement—they'll have immediate access to resources and somewhere to turn."

Fire Chief Brian Fennessy
Orange County (CA) Fire Authority

"Ensuring firefighters are emotionally prepared to take care of the public, when the public is having the worst day of their lives, is what keeps fire chiefs up at night. This unique and very affordable solution from Cordico benefits the firefighters, the public, and the community's leadership."

Deputy Chief Billy Goldfeder
Loveland-Symmes (OH) Fire Department

LEXIPOL

SOLUTIONS PROPOSAL

PREPARED FOR:
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Unknown Wesley Katz
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925-321-5744

PREPARED BY:
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Executive Summary

Public safety agencies and local government organizations today face challenges of keeping personnel safe and healthy, reducing risk and maintaining a positive reputation. Add to that the dynamically changing legislative landscape and evolving best practices, and even the most progressive, forward-thinking departments can struggle to keep up.

Lexipol's solutions are designed to save you time and money while protecting your personnel and your community. Our team consists of professionals with expertise in public safety law, policy, state and federal accreditation, training, mental and physical wellness and grants. We continually monitor changes and trends in legislation, case law and best practices and use this knowledge to create policies, training, wellness resources and funding services that minimize risk and help you effectively serve your community.

THE LEXIPOL ADVANTAGE

Lexipol was founded by public safety experts who saw a need for a better, safer way to run a public safety agency. Since the company launch in 2003, Lexipol has grown to form an entire risk management solution for public safety and local government. Today, we serve more than 10,000 agencies and municipalities and 2 million public safety and government professionals with a range of informational and technological solutions to meet the challenges facing these dynamic industries. In addition to providing policy management, accreditation, online training, wellness resources, and grant assistance, we provide 24/7 industry news and analysis through the digital communities Police1, FireRescue1, Corrections1, EMS1 and Gov1.

Our customers choose Lexipol to make an investment in the safety and security of their personnel, their agencies and their communities. We help agencies address issues that create substantial risk, including:

- Inconsistent and outdated polices
- Lack of technology to easily update and issue policies and training electronically
- Unchecked mental health needs of staff
- Difficulty keeping up with new and changing legislation and practices
- Inability to produce policy acknowledgment and training documentation
- Unfamiliarity of city legal resources with the intricacies of public safety law
- The need to secure grant funding for critical equipment, infrastructure and personnel

Lexipol is backed by the expertise of 440 employees with more than 2,075 years of combined experience in constitutional law, civil rights, ADA and discrimination, mental health, psychology, labor negotiations, Internal Affairs, use of force, hazmat, instructional design, federal and state grants and a whole lot more. That means no more trying to figure out policy, achieve accreditation, develop training or wellness content, or secure funding on your own. You can draw on the experience of our dedicated team members who have researched, taught and lived these issues.

We look forward to working with Calaveras Consolidated Fire Protection District to address your unique challenges.

Scope of Services

Cordico Firefighter Wellness App
Fire service leaders are increasingly recognizing the need to provide personnel with mental and behavioral health resources. The Cordico firefighter wellness solution enables departments to provide confidential, mobile wellness resources. Our fire service app includes a complete range of self-assessments as well as continuously updated videos and guides on more than 60 behavioral health topics - all designed specifically for first responders. The anonymity of all users is paramount and no personal information is ever collected or stored. Also included are online accredited wellness courses covering such topics as managing stress, post-traumatic stress disorder, family and work relationships, and fitness and nutrition.

- Connect your personnel to confidential assessments and counseling resources
- Strengthen your wellness culture and empower your peer support team
- Help firefighters cope with the effects of critical events and chronic exposure
- Improve firefighter decision-making, empathy and resiliency, which in turn enhances the service your department provides
- Support department retirees and family members (included with agency subscription)

Peer & Chaplain Support
Peer support teams and chaplains provide invaluable assistance to public safety personnel—but personnel don't always know who these members are or how to contact them. Cordico's wellness app allows for the integration of your agency's peer support and/or chaplains, making it easy for members to quickly connect when they need support.

- Include profiles of your peer support team and chaplains in the app so personnel can see their photos, backgrounds, areas of specialty, etc.
- Enable confidential, one-on-one conversations without the need to go through an agency or city intranet
- Increase usage of peer support and chaplain services

CrisisAlert® One-Touch Dialing
Cordico's CrisisAlert one-touch dialing feature allows personnel who need help to instantly dial all peer support or chaplains with one touch—anonymously. The peer support team member or chaplain who answers first is connected to the employee seeking assistance, and the other team members don't know who called. This creates an easier and more trusted way for personnel to access your peer support and chaplain resources. Your personnel don't have to determine who's on duty, who's available or how to reach them.

Therapist Finder
Individuals in crisis or suffering from depression or anxiety don't need additional roadblocks to getting help. But often, that's exactly what happens when public safety personnel try to access counseling services. Cordico's Therapist Finder simplifies and streamlines the process, making it easy for your personnel to locate therapists near them that are approved through the agency's insurance plan.

- Include profiles of therapists in the app so personnel can see their photos, backgrounds, areas of specialty, etc.
- Connect personnel to therapists your agency has vetted as being experienced with treating public safety personnel
- Show therapist locations on an interactive map
- Enable personnel to instantly contact therapists for in-person visit or teletherapy via a confidential portal

Fitness, Nutrition, and Injury Prevention
Recognizing that wellbeing is not just about mental and emotional health, Cordico's wellness apps include resources to support fitness, nutrition and injury prevention.

- Yoga videos offered through an exclusive partnership with Yoga For First Responders
- Nutrition guides
- Guided meditations
- Sleep sounds
- Ability to add agency-specific fitness videos, workout of the day, training videos, etc.

Proposal

Prepared By: Mary James
Phone: (469) 676-8110
Email: mjames@lexipol.com

Quote #: Q-65349-1
Date: 7/20/2023
Valid Through: 10/18/2023

Overview

Lexipol empowers first responders and public servants to best meet the needs of their residents safely and responsibly. We are the experts in policy, training and wellness support, committed to improving the quality of life for all community members. Our solutions include state-specific policies, online learning, behavioral health resources, funding assistance, and industry news and information offered through the websites Police1, FireRescue1, EMS1 and Corrections1. Lexipol serves more than 2 million public safety and government professionals in over 10,000 agencies and municipalities. The services proposed below are designed to meet your agency's specific goals and needs.

Annual Subscription

QTY	DESCRIPTION	UNIT PRICE	EXTENDED
1	CordicoFire Firefighter Wellness App (12 Months)	USD 3,999.00	USD 3,999.00
	Subscription Line Items Total		**USD 3,999.00**
			USD 3,999.00
		Annual Subscription TOTAL:	USD 3,999.00

CaliforniaChoice Program **CALAVARES CONSOLIDATED FIRE** **Effective: January 1, 2024**

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 95242 | County: San Joaquin
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 305.02	$ 305.02
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 308.10	$ 308.10
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 308.94	$ 308.94
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 316.03	$ 316.03
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 320.18	$ 320.18
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 338.95	$ 338.95
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 345.27	$ 345.27
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 350.48	$ 350.48
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 362.92	$ 362.92
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 367.78	$ 367.78
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 370.18	$ 370.18
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 387.16	$ 387.16
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 389.76	$ 389.76
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 397.58	$ 397.58
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 410.33	$ 410.33
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 422.81	$ 422.81
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 428.08	$ 428.08
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 429.38	$ 429.38
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 450.14	$ 450.14
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 456.61	$ 456.61
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 462.16	$ 462.16
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 464.48	$ 464.48
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 465.54	$ 465.54
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 465.54	$ 465.54
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 465.89	$ 465.89
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 472.51	$ 472.51
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 484.15	$ 484.15
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 486.28	$ 486.28
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 490.73	$ 490.73
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 491.97	$ 491.97
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 492.63	$ 492.63
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 498.84	$ 498.84
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 502.45	$ 502.45
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 507.07	$ 507.07
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 517.35	$ 517.35
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 526.89	$ 526.89
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 544.65	$ 544.65
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 560.61	$ 560.61
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 593.02	$ 593.02
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 593.02	$ 593.02
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 654.78	$ 654.78

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 391.17	$ 391.17
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 395.89	$ 395.89
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 420.12	$ 420.12

Employee Enrollment Worksheet (2 of 10)

[redacted]
Zip: 95242 | County: San Joaquin
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 425.12	$ 425.12
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 426.03	$ 426.03
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 428.93	$ 428.93
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 457.55	$ 457.55
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 460.65	$ 460.65
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 494.45	$ 494.45
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 499.22	$ 499.22
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 516.31	$ 516.31
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 521.50	$ 521.50
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 554.50	$ 554.50
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 560.07	$ 560.07
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 644.73	$ 644.73

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 95242 | County: San Joaquin

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente		Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑱		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]
Zip: 95242 | County: San Joaquin

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]
Zip: 95242 | County: San Joaquin

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 95242 | County: San Joaquin

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 95242 | County: San Joaquin

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 95242 | County: San Joaquin

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

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Zip: 95242 | County: San Joaquin

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

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Zip: 95242 | County: San Joaquin

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 94518 | County: Contra Costa
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 303.82	$ 303.82
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 306.87	$ 306.87
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 307.71	$ 307.71
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 314.77	$ 314.77
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 318.91	$ 318.91
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 337.60	$ 337.60
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 343.91	$ 343.91
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 349.08	$ 349.08
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 361.47	$ 361.47
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 366.31	$ 366.31
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 368.70	$ 368.70
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 385.63	$ 385.63
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 388.20	$ 388.20
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 396.01	$ 396.01
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 408.69	$ 408.69
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 421.12	$ 421.12
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 426.37	$ 426.37
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 427.68	$ 427.68
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 448.34	$ 448.34
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 454.79	$ 454.79
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 460.32	$ 460.32
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 462.62	$ 462.62
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 463.69	$ 463.69
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 463.69	$ 463.69
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 464.03	$ 464.03
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 470.64	$ 470.64
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 482.22	$ 482.22
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 484.34	$ 484.34
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 488.77	$ 488.77
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 490.01	$ 490.01
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 490.67	$ 490.67
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 496.85	$ 496.85
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 500.45	$ 500.45
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 505.05	$ 505.05
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 515.30	$ 515.30
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 524.80	$ 524.80
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 542.48	$ 542.48
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 558.37	$ 558.37
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 590.66	$ 590.66
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 590.66	$ 590.66
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 652.17	$ 652.17

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 389.61	$ 389.61
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 394.31	$ 394.31
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 418.45	$ 418.45

Employee Enrollment Worksheet (2 of 10)

[redacted]
Zip: 94518 | County: Contra Costa
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 423.43	$ 423.43
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 424.33	$ 424.33
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 427.22	$ 427.22
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 455.73	$ 455.73
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 458.81	$ 458.81
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 492.48	$ 492.48
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 497.23	$ 497.23
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 514.25	$ 514.25
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 519.42	$ 519.42
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 552.29	$ 552.29
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 557.84	$ 557.84
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 642.16	$ 642.16

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 94518 | County: Contra Costa

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente		Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑩		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]
Zip: 94518 | County: Contra Costa

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]
Zip: 94518 | County: Contra Costa

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 94518 | County: Contra Costa

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 94518 | County: Contra Costa

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 94518 | County: Contra Costa

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

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HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

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Zip: 94518 | County: Contra Costa

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 94568 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 330.24	$ 330.24
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 333.57	$ 333.57
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 334.48	$ 334.48
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 342.16	$ 342.16
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 346.65	$ 346.65
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 366.97	$ 366.97
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 373.82	$ 373.82
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 379.45	$ 379.45
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 392.92	$ 392.92
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 398.18	$ 398.18
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 400.78	$ 400.78
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 419.17	$ 419.17
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 421.98	$ 421.98
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 430.45	$ 430.45
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 444.25	$ 444.25
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 457.76	$ 457.76
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 463.47	$ 463.47
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 464.88	$ 464.88
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 487.35	$ 487.35
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 494.36	$ 494.36
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 500.37	$ 500.37
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 502.87	$ 502.87
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 504.03	$ 504.03
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 504.03	$ 504.03
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 504.41	$ 504.41
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 511.57	$ 511.57
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 524.18	$ 524.18
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 526.48	$ 526.48
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 531.30	$ 531.30
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 532.65	$ 532.65
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 533.36	$ 533.36
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 540.08	$ 540.08
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 543.99	$ 543.99
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 548.98	$ 548.98
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 560.12	$ 560.12
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 570.44	$ 570.44
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 589.68	$ 589.68
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 606.95	$ 606.95
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 642.05	$ 642.05
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 642.05	$ 642.05
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 708.91	$ 708.91

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 423.51	$ 423.51
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 428.61	$ 428.61
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 454.86	$ 454.86

Employee Enrollment Worksheet (2 of 10)

[redacted]
Zip: 94568 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 460.27	$ 460.27
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 461.25	$ 461.25
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 464.39	$ 464.39
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 495.38	$ 495.38
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 498.73	$ 498.73
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 535.33	$ 535.33
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 540.49	$ 540.49
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 558.99	$ 558.99
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 564.61	$ 564.61
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 600.34	$ 600.34
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 606.37	$ 606.37
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 698.03	$ 698.03

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 94568 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente		Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑱		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]
Zip: 94568 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]
Zip: 94568 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 94568 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 94568 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 94568 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

[redacted]
Zip: 94568 | County: Alameda

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

[redacted]
Zip: 94568 | County: Alameda

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 95307 | County: Stanislaus
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 344.82	$ 344.82
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 348.30	$ 348.30
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 349.25	$ 349.25
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 357.27	$ 357.27
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 361.95	$ 361.95
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 383.18	$ 383.18
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 390.32	$ 390.32
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 396.21	$ 396.21
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 410.27	$ 410.27
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 415.76	$ 415.76
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 418.48	$ 418.48
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 437.68	$ 437.68
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 440.61	$ 440.61
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 449.46	$ 449.46
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 463.87	$ 463.87
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 477.97	$ 477.97
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 483.93	$ 483.93
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 485.41	$ 485.41
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 508.87	$ 508.87
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 516.19	$ 516.19
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 522.47	$ 522.47
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 525.08	$ 525.08
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 526.29	$ 526.29
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 526.29	$ 526.29
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 526.68	$ 526.68
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 534.16	$ 534.16
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 547.32	$ 547.32
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 549.73	$ 549.73
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 554.76	$ 554.76
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 556.17	$ 556.17
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 556.91	$ 556.91
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 563.93	$ 563.93
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 568.01	$ 568.01
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 573.23	$ 573.23
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 584.85	$ 584.85
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 595.63	$ 595.63
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 615.72	$ 615.72
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 633.75	$ 633.75
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 670.40	$ 670.40
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 670.40	$ 670.40
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 740.21	$ 740.21

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 442.21	$ 442.21
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 447.54	$ 447.54
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 474.94	$ 474.94

Employee Enrollment Worksheet (2 of 10)

[redacted]

Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 480.59	$ 480.59
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 481.61	$ 481.61
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 484.89	$ 484.89
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 517.25	$ 517.25
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 520.75	$ 520.75
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 558.96	$ 558.96
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 564.36	$ 564.36
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 583.67	$ 583.67
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 589.54	$ 589.54
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 626.85	$ 626.85
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 633.15	$ 633.15
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 728.85	$ 728.85

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente	Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑩		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

[redacted]
Zip: 95307 | County: Stanislaus

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 5)

[redacted]
Zip: 95246 | County: Calaveras
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 460.91	$ 460.91
2	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 466.47	$ 466.47
3	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 495.03	$ 495.03
4	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 500.92	$ 500.92
5	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 501.98	$ 501.98
6	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 505.40	$ 505.40
7	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 539.13	$ 539.13
8	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 542.77	$ 542.77
9	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 582.60	$ 582.60
10	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 588.22	$ 588.22
11	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 608.36	$ 608.36
12	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 614.47	$ 614.47
13	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 653.36	$ 653.36
14	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 659.92	$ 659.92
15	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 759.68	$ 759.68

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (2 of 5)

[redacted]
Zip: 95246 | County: Calaveras

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	1 **BRONZE PPO D**①	2 **BRONZE PPO B**①	3 **BRONZE PPO C**①	4 **BRONZE PPO A**①	5 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (3 of 5)

[redacted]
Zip: 95246 | County: Calaveras

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	6 **SILVER PPO B**①	7 **SILVER PPO D**①	8 **SILVER PPO C**①	9 **GOLD PPO D**①	10 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 5)

[redacted]
Zip: 95246 | County: Calaveras

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	11 **GOLD PPO G**①	12 **GOLD PPO C**①	13 **GOLD PPO F**①	14 **GOLD PPO E**①	15 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 5)

[redacted]
Zip: 95246 | County: Calaveras

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 94588 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 359.41	$ 359.41
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 363.02	$ 363.02
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 364.02	$ 364.02
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 372.37	$ 372.37
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 377.26	$ 377.26
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 399.38	$ 399.38
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 406.83	$ 406.83
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 412.96	$ 412.96
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 427.62	$ 427.62
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 433.35	$ 433.35
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 436.17	$ 436.17
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 456.19	$ 456.19
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 459.25	$ 459.25
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 468.47	$ 468.47
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 483.48	$ 483.48
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 498.19	$ 498.19
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 504.40	$ 504.40
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 505.93	$ 505.93
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 530.39	$ 530.39
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 538.02	$ 538.02
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 544.56	$ 544.56
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 547.28	$ 547.28
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 548.55	$ 548.55
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 548.55	$ 548.55
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 548.95	$ 548.95
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 556.75	$ 556.75
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 570.47	$ 570.47
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 572.98	$ 572.98
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 578.22	$ 578.22
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 579.69	$ 579.69
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 580.46	$ 580.46
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 587.78	$ 587.78
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 592.03	$ 592.03
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 597.47	$ 597.47
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 609.58	$ 609.58
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 620.82	$ 620.82
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 641.75	$ 641.75
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 660.56	$ 660.56
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 698.75	$ 698.75
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 698.75	$ 698.75
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 771.52	$ 771.52

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 460.91	$ 460.91
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 466.47	$ 466.47
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 495.03	$ 495.03

Employee Enrollment Worksheet (2 of 10)

[redacted]
Zip: 94588 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 500.92	$ 500.92
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 501.98	$ 501.98
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 505.40	$ 505.40
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 539.13	$ 539.13
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 542.77	$ 542.77
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 582.60	$ 582.60
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 588.22	$ 588.22
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 608.36	$ 608.36
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 614.47	$ 614.47
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 653.36	$ 653.36
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 659.92	$ 659.92
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 759.68	$ 759.68

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 94588 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente	Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑱		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]
Zip: 94588 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]
Zip: 94588 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 94588 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 94588 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 94588 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

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Zip: 94588 | County: Alameda

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

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Zip: 94588 | County: Alameda

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 94550 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 305.02	$ 305.02
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 308.10	$ 308.10
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 308.94	$ 308.94
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 316.03	$ 316.03
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 320.18	$ 320.18
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 338.95	$ 338.95
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 345.27	$ 345.27
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 350.48	$ 350.48
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 362.92	$ 362.92
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 367.78	$ 367.78
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 370.18	$ 370.18
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 387.16	$ 387.16
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 389.76	$ 389.76
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 397.58	$ 397.58
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 410.33	$ 410.33
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 422.81	$ 422.81
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 428.08	$ 428.08
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 429.38	$ 429.38
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 450.14	$ 450.14
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 456.61	$ 456.61
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 462.16	$ 462.16
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 464.48	$ 464.48
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 465.54	$ 465.54
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 465.54	$ 465.54
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 465.89	$ 465.89
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 472.51	$ 472.51
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 484.15	$ 484.15
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 486.28	$ 486.28
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 490.73	$ 490.73
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 491.97	$ 491.97
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 492.63	$ 492.63
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 498.84	$ 498.84
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 502.45	$ 502.45
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 507.07	$ 507.07
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 517.35	$ 517.35
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 526.89	$ 526.89
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 544.65	$ 544.65
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 560.61	$ 560.61
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 593.02	$ 593.02
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 593.02	$ 593.02
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 654.78	$ 654.78

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 391.17	$ 391.17
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 395.89	$ 395.89
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 420.12	$ 420.12

Employee Enrollment Worksheet (2 of 10)

[redacted]
Zip: 94550 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 425.12	$ 425.12
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 426.03	$ 426.03
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 428.93	$ 428.93
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 457.55	$ 457.55
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 460.65	$ 460.65
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 494.45	$ 494.45
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 499.22	$ 499.22
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 516.31	$ 516.31
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 521.50	$ 521.50
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 554.50	$ 554.50
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 560.07	$ 560.07
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 644.73	$ 644.73

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 94550 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente	Kaiser Permanente	Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3 **BRONZE HMO B**	4 **BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**	**Full**	**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes	No	No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦	$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦	$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%	$60 Copay⑨	$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%	50%	60%		100%
Specialist Visit		$95 Copay⑥		100%	$80 Copay⑨	$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%	50%	60%		100%
Emergency Room		60%		100%	50%	60%		100%
Urgent Care		$60 Copay⑥		100%	$60 Copay⑨	$60 Copay⑫		100%
Out-Patient Surgery		60%		100%	50%	60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)	$20 Copay (ded waived)	$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)	50% (up to $500 per prescription; comb. Med/Rx ded) ⑩	$500 / $1,000 Ded 60% (up to $500 per prescription)⑩		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100	$8,600 / $17,200⑧	$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente	Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8 **SILVER HMO E**	9 **SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**	**Full**	**Full**		**Full**
HSA Compatible		Yes		Yes	No	No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①	$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦	$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬	$65 Copay (ded waived)	$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure	$75 Copay	$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay	$100 Copay (ded waived)	$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%	55%	55%		65%
Emergency Room		75%		75%	55%	55%		65%
Urgent Care		75%		$35 Copay	$65 Copay (ded waived)	$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%	55%	55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④	$20 Copay (ded waived)	$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④	$100 Copay (comb. Med/Rx ded)	$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②	$9,100 / $18,200⑧	$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente	Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13 **GOLD HMO E**	14 **GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**	**Full**	**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No	Yes	Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①	$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮	$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬	85%	80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)	85%	80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)	85%	80%		$90 Copay
HOSPITAL SERVICES		55%		65%	85%	80%		50%
Emergency Room		55%		65%	85%	80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)	85%	80%		$55 Copay
Out-Patient Surgery		55%		65%	85%	80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④	$15 Copay (comb. Med/Rx ded)	$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④	$45 Copay (comb. Med/Rx ded)	$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②	$3,700 / $7,400⑧	$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]
Zip: 94550 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]
Zip: 94550 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 94550 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 94550 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 94550 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

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Zip: 94550 | County: Alameda

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

[redacted]
Zip: 94550 | County: Alameda

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

CaliforniaChoice Program **CALAVARES CONSOLIDATED FIRE** **Effective: January 1, 2024**

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 94605 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 330.24	$ 330.24
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 333.57	$ 333.57
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 334.48	$ 334.48
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 342.16	$ 342.16
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 346.65	$ 346.65
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 366.97	$ 366.97
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 373.82	$ 373.82
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 379.45	$ 379.45
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 392.92	$ 392.92
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 398.18	$ 398.18
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 400.78	$ 400.78
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 419.17	$ 419.17
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 421.98	$ 421.98
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 430.45	$ 430.45
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 444.25	$ 444.25
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 457.76	$ 457.76
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 463.47	$ 463.47
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 464.88	$ 464.88
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 487.35	$ 487.35
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 494.36	$ 494.36
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 500.37	$ 500.37
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 502.87	$ 502.87
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 504.03	$ 504.03
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 504.03	$ 504.03
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 504.41	$ 504.41
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 511.57	$ 511.57
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 524.18	$ 524.18
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 526.48	$ 526.48
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 531.30	$ 531.30
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 532.65	$ 532.65
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 533.36	$ 533.36
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 540.08	$ 540.08
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 543.99	$ 543.99
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 548.98	$ 548.98
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 560.12	$ 560.12
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 570.44	$ 570.44
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 589.68	$ 589.68
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 606.95	$ 606.95
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 642.05	$ 642.05
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 642.05	$ 642.05
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 708.91	$ 708.91

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 423.51	$ 423.51
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 428.61	$ 428.61
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 454.86	$ 454.86

Employee Enrollment Worksheet (2 of 10)

[redacted]
Zip: 94605 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 460.27	$ 460.27
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 461.25	$ 461.25
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 464.39	$ 464.39
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 495.38	$ 495.38
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 498.73	$ 498.73
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 535.33	$ 535.33
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 540.49	$ 540.49
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 558.99	$ 558.99
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 564.61	$ 564.61
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 600.34	$ 600.34
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 606.37	$ 606.37
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 698.03	$ 698.03

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 94605 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente	Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑩		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]
Zip: 94605 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]
Zip: 94605 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 94605 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 94605 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 94605 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

[redacted]
Zip: 94605 | County: Alameda

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

[redacted]
Zip: 94605 | County: Alameda

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 94550 | County: Alameda
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 303.82	$ 303.82
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 306.87	$ 306.87
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 307.71	$ 307.71
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 314.77	$ 314.77
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 318.91	$ 318.91
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 337.60	$ 337.60
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 343.91	$ 343.91
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 349.08	$ 349.08
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 361.47	$ 361.47
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 366.31	$ 366.31
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 368.70	$ 368.70
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 385.63	$ 385.63
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 388.20	$ 388.20
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 396.01	$ 396.01
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 408.69	$ 408.69
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 421.12	$ 421.12
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 426.37	$ 426.37
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 427.68	$ 427.68
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 448.34	$ 448.34
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 454.79	$ 454.79
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 460.32	$ 460.32
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 462.62	$ 462.62
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 463.69	$ 463.69
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 463.69	$ 463.69
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 464.03	$ 464.03
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 470.64	$ 470.64
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 482.22	$ 482.22
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 484.34	$ 484.34
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 488.77	$ 488.77
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 490.01	$ 490.01
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 490.67	$ 490.67
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 496.85	$ 496.85
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 500.45	$ 500.45
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 505.05	$ 505.05
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 515.30	$ 515.30
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 524.80	$ 524.80
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 542.48	$ 542.48
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 558.37	$ 558.37
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 590.66	$ 590.66
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 590.66	$ 590.66
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 652.17	$ 652.17

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 389.61	$ 389.61
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 394.31	$ 394.31
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 418.45	$ 418.45

Employee Enrollment Worksheet (2 of 10)

[redacted]

Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Employee Only
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 423.43	$ 423.43
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 424.33	$ 424.33
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 427.22	$ 427.22
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 455.73	$ 455.73
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 458.81	$ 458.81
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 492.48	$ 492.48
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 497.23	$ 497.23
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 514.25	$ 514.25
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 519.42	$ 519.42
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 552.29	$ 552.29
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 557.84	$ 557.84
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 642.16	$ 642.16

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]
Zip: 94550 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente	Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3 **BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**	**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes	No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦	$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%	$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%	50%		60%		100%
Specialist Visit		$95 Copay⑥		100%	$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%	50%		60%		100%
Emergency Room		60%		100%	50%		60%		100%
Urgent Care		$60 Copay⑥		100%	$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%	50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)	$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)	50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑩		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100	$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8 **SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**	**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes	No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①	$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬	$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure	$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay	$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%	55%		55%		65%
Emergency Room		75%		75%	55%		55%		65%
Urgent Care		75%		$35 Copay	$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%	55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④	$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④	$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②	$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13 **GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**	**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No	Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①	$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬	85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)	85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)	85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%	85%		80%		50%
Emergency Room		55%		65%	85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)	85%		80%		$55 Copay
Out-Patient Surgery		55%		65%	85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④	$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④	$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②	$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]

Zip: 94550 | County: Alameda

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan	Health Net	Kaiser Permanente	Sutter Health Plus	Kaiser Permanente	Health Net
Metal Tier & Plan Type	16 **SILVER HMO D**	17 **GOLD HMO D**	18 **GOLD HMO A**	19 **GOLD HMO B**	20 **GOLD HMO B**
Network Name	**Full**	**Full**	**Sutter Health Plus**	**Full**	**WholeCare**
HSA Compatible	No	No	No	No	No
Deductible	None	$1,000 / $2,000 (applies to Max OOP)⑦	$1,500 / $3,000 (applies to Max OOP)①	$250 / $500 (applies to Max OOP)⑦	None
DR. OFFICE VISITS	$55 Copay	$40 Copay (ded waived)	$30 Copay⑬	$35 Copay (ded waived)	$40 Copay
Lab and X-Ray	$60 Copay	$60 Copay (ded waived)	$50 Copay per procedure	$55 Copay (ded waived)	$50 Copay
Specialist Visit	$90 Copay	$60 Copay (ded waived)	$50 Copay	$55 Copay (ded waived)	$60 Copay
HOSPITAL SERVICES	50%	$600 Copay per day - 5 days max	80%	$600 Copay per day, 5 days max	$750 Copay per day - 5 days max
Emergency Room	50%	$350 Copay (ded waived; waived if admitted)	$200 Copay (waived if admitted)	$250 Copay (waived if admitted)	$350 Copay (waived if admitted)
Urgent Care	$55 Copay	$40 Copay (ded waived)	$30 Copay	$35 Copay (ded waived)	$40 Copay
Out-Patient Surgery	50%	$350 Copay per procedure (ded waived)	80%	$335 Copay per procedure	$1,200 Copay
RX BENEFITS - Generic	$20 Copay (ded waived)⑱	$20 Copay (ded waived)	$15 copay (overall ded waived)④	$15 Copay (overall ded waived)	$15 Copay⑱
RX BENEFITS - Formulary Brand	$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰	$250 / $500 Ded - $50 Copay	$30 copay (overall ded waived)④	$40 Copay (overall ded waived)	$50 Copay⑱
Out-of-Pocket Max-Ind/Fam	$9,450 / $18,900	$7,800 / $15,600⑧	$5,000 / $10,000②	$7,800 / $15,600⑧	$7,500 / $15,000

Health Plan	Health Net	Kaiser Permanente	Anthem Blue Cross	Anthem Blue Cross	Health Net
Metal Tier & Plan Type	21 **GOLD HMO C**	22 **GOLD HMO C**	23 **SILVER HMO A**⑱	24 **SILVER HMO B**⑱	25 **GOLD HMO A**
Network Name	**WholeCare**	**Full**	**Select HMO**	**CaliforniaCare HMO**	**WholeCare**
HSA Compatible	No	No	No	No	No
Deductible	None	None	$2,200 / $4,400 (applies to Max OOP)⑲	$2,200 / $4,400 (applies to Max OOP)⑲	None
DR. OFFICE VISITS	$35 Copay	$35 Copay	$60 Copay (ded waived)	$60 Copay (ded waived)	$30 Copay
Lab and X-Ray	$50 Copay	$40 Copay	$20 Copay (ded waived)㉑	$20 Copay (ded waived)㉑	$40 Copay
Specialist Visit	$55 Copay	$60 Copay	$95 Copay (ded waived)	$95 Copay (ded waived)	$50 Copay
HOSPITAL SERVICES	$750 Copay per day - 4 days max	$600 Copay per day - 5 days max	55%	55%	$750 Copay per day - 4 days max
Emergency Room	$325 Copay (waived if admitted)	$350 Copay (waived if admitted)	$350 Copay (waived if admitted) - 55%	$350 Copay (waived if admitted) - 55%	$325 Copay (waived if admitted)
Urgent Care	$35 Copay	$35 Copay	$60 Copay (ded waived)	$60 Copay (ded waived)	$30 Copay
Out-Patient Surgery	$1,200 Copay	$320 Copay per procedure	55%	55%	$900 Copay
RX BENEFITS - Generic	$15 Copay⑱	$15 Copay	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒	$20 Copay⑱
RX BENEFITS - Formulary Brand	$50 Copay⑱	$50 Copay	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒	$50 Copay⑱
Out-of-Pocket Max-Ind/Fam	$7,350 / $14,700	$7,700 / $15,400⑧	$9,100 / $18,200㉑	$9,100 / $18,200㉑	$7,250 / $14,500

Health Plan	Sutter Health Plus	Health Net	Kaiser Permanente	Health Net	Kaiser Permanente
Metal Tier & Plan Type	26 **GOLD HMO B**	27 **GOLD HMO F**	28 **PLATINUM HMO C**	29 **GOLD HMO E**	30 **PLATINUM HMO B**
Network Name	**Sutter Health Plus**	**Full**	**Full**	**Full**	**Full**
HSA Compatible	No	No	No	No	No
Deductible	$250 / $500 (applies to Max OOP)①	None	$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦	None	None
DR. OFFICE VISITS	$35 Copay (ded waived)⑬	$40 Copay	$30 Copay (ded waived)	$35 Copay	$20 Copay
Lab and X-Ray	$55 Copay per procedure (ded waived)	$50 Copay	$50 Copay (ded waived)	$50 Copay	$30 Copay
Specialist Visit	$55 Copay (ded waived)	$60 Copay	$50 Copay (ded waived)	$55 Copay	$30 Copay
HOSPITAL SERVICES	$600 Copay per day - 5 days max per admit	$750 Copay per day - 5 days max	$500 Copay per admit	$750 Copay per day - 4 days max	$250 Copay per day - 5 days max
Emergency Room	$250 Copay (waived if admitted)	$350 Copay (waived if admitted)	$250 Copay (ded waived; waived if admitted)	$325 Copay (waived if admitted)	$150 Copay (waived if admitted)
Urgent Care	$35 Copay (ded waived)	$40 Copay	$30 Copay (ded waived)	$35 Copay	$20 Copay
Out-Patient Surgery	$300 Copay	$1,200 Copay	$300 Copay (ded waived) per procedure	$1,200 Copay	$125 Copay per procedure
RX BENEFITS - Generic	$15 Copay (overall ded waived)④	$15 Copay⑱	$10 Copay (ded waived)	$15 Copay⑱	$5 Copay
RX BENEFITS - Formulary Brand	$40 Copay (overall ded waived)④	$50 Copay⑱	$20 Copay (ded waived)	$50 Copay⑱	$20 Copay
Out-of-Pocket Max-Ind/Fam	$7,800 / $15,600②	$7,500 / $15,000	$3,000 / $6,000⑧	$7,350 / $14,700	$4,500 / $9,000

Employee Enrollment Worksheet (5 of 10)

[redacted]

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan	Health Net	Health Net	Kaiser Permanente	Health Net	Sutter Health Plus
Metal Tier & Plan Type	31 **PLATINUM HMO C**	32 **GOLD HMO G**	33 **PLATINUM HMO A**	34 **PLATINUM HMO F**	35 **PLATINUM HMO A**
Network Name	**WholeCare**	**Full**	**Full**	**WholeCare**	**Sutter Health Plus**
HSA Compatible	No	No	No	No	No
Deductible	None	None	None	None	None
DR. OFFICE VISITS	$30 Copay	$30 Copay	$10 Copay	100%	$20 Copay⑬
Lab and X-Ray	$30 Copay	$50 Copay	$40 Copay	100%	$30 Copay per procedure
Specialist Visit	$50 Copay	$50 Copay	$20 Copay	100%	$30 Copay
HOSPITAL SERVICES	$600 Copay per day - 4 days max	$750 Copay per day - 4 days max	$500 Copay per admit	$500 Copay per day - 4 days max	$250 Copay per day - 5 days max per admit
Emergency Room	$250 Copay (waived if admitted)	$325 Copay (waived if admitted)	$200 Copay (waived if admitted)	$275 Copay (waived if admitted)	$150 Copay (waived if admitted)
Urgent Care	$30 Copay	$30 Copay	$10 Copay	100%	$20 Copay
Out-Patient Surgery	$500 Copay	$900 Copay	$300 Copay per procedure	$500 Copay	$100 Copay
RX BENEFITS - Generic	$5 Copay⑯	$20 Copay⑯	$5 Copay	100%⑯	$5 Copay④
RX BENEFITS - Formulary Brand	$30 Copay⑯	$50 Copay⑯	$15 Copay	$30 Copay⑯	$20 Copay④
Out-of-Pocket Max-Ind/Fam	$2,700/ $5,400	$7,250 / $14,500	$3,000 / $6,000	$3,300 / $6,600	$4,500 / $9,000②

Health Plan	Sutter Health Plus	Health Net	Health Net	Anthem Blue Cross	Anthem Blue Cross
Metal Tier & Plan Type	36 **PLATINUM HMO B**	37 **PLATINUM HMO E**	38 **PLATINUM HMO H**	39 **GOLD HMO B⑱**	40 **GOLD HMO A⑱**
Network Name	**Sutter Health Plus**	**Full**	**Full**	**CaliforniaCare HMO**	**Select HMO**
HSA Compatible	No	No	No	No	No
Deductible	None	None	None	None	None
DR. OFFICE VISITS	$15 Copay⑬	$30 Copay	100%	$30 Copay	$30 Copay
Lab and X-Ray	$25 Copay per procedure	$30 Copay	100%	$15 Copay㉑	$15 Copay㉑
Specialist Visit	$30 Copay	$50 Copay	100%	$60 Copay	$60 Copay
HOSPITAL SERVICES	$250 Copay per day - 5 days max per admit	$600 Copay per day - 4 days max	$500 Copay per day - 4 days max	$550 Copay per day - 4 days max per admit	$550 Copay per day - 4 days max per admit
Emergency Room	$100 Copay (waived if admitted)	$250 Copay (waived if admitted)	$275 Copay (waived if admitted)	$325 Copay (waived if admitted)	$325 Copay (waived if admitted)
Urgent Care	$15 Copay	$30 Copay	100%	$30 Copay	$30 Copay
Out-Patient Surgery	$100 Copay	$500 Copay	$500 Copay	$500 Copay	$500 Copay
RX BENEFITS - Generic	$5 Copay④	$5 Copay⑯	100%⑯	Level 1 $10 Copay / Level 2 $20 Copay㉒	Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand	$15 Copay④	$30 Copay⑯	$30 Copay⑯	Level 1 $50 Copay / Level 2 $60 Copay㉒	Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam	$3,500 / $7,000②	$2,700/ $5,400	$3,300 / $6,600	$7,250 / $14,500⑳	$7,250 / $14,500⑳

Health Plan	Anthem Blue Cross
Metal Tier & Plan Type	41 **PLATINUM HMO A⑱**
Network Name	**Select HMO**
HSA Compatible	No
Deductible	None
DR. OFFICE VISITS	$20 Copay
Lab and X-Ray	$10 Copay㉑
Specialist Visit	$40 Copay
HOSPITAL SERVICES	$300 Copay per day - 3 days max per admit
Emergency Room	$275 Copay (waived if admitted)
Urgent Care	$20 Copay
Out-Patient Surgery	$250 Copay
RX BENEFITS - Generic	Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand	Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam	$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]
Zip: 94550 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]
Zip: 94550 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]
Zip: 94550 | County: Alameda

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

[redacted]
Zip: 94550 | County: Alameda

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

[redacted]

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 5)

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Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution: Employee Only	Additional For Spouse	Additional For Children (0-20)[1]	Your Cost per Pay Period: Employee Only	Additional For Family
1	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 528.70	$ 479.22	$ 596.10	$ 528.70	$ 1,075.32
2	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 535.08	$ 485.00	$ 603.30	$ 535.08	$ 1,088.30
3	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 567.84	$ 514.69	$ 640.22	$ 567.84	$ 1,154.91
4	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 574.59	$ 520.82	$ 647.84	$ 574.59	$ 1,168.66
5	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 575.82	$ 521.93	$ 649.22	$ 575.82	$ 1,171.15
6	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 579.74	$ 525.48	$ 653.64	$ 579.74	$ 1,179.12
7	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 618.43	$ 560.55	$ 697.26	$ 618.43	$ 1,257.81
8	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 622.61	$ 564.34	$ 701.98	$ 622.61	$ 1,266.32
9	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 668.30	$ 605.75	$ 753.50	$ 668.30	$ 1,359.25
10	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 674.74	$ 611.59	$ 760.76	$ 674.74	$ 1,372.35
11	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 697.84	$ 632.53	$ 786.80	$ 697.84	$ 1,419.33
12	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 704.85	$ 638.89	$ 794.72	$ 704.85	$ 1,433.61
13	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 749.46	$ 679.32	$ 845.00	$ 749.46	$ 1,524.32
14	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 756.99	$ 686.14	$ 853.50	$ 756.99	$ 1,539.64
15	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 871.41	$ 789.86	$ 982.50	$ 871.41	$ 1,772.36

1. Premium reflects 2 children age 0 20.

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (2 of 5)

[redacted]

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	1 **BRONZE PPO D**①	2 **BRONZE PPO B**①	3 **BRONZE PPO C**①	4 **BRONZE PPO A**①	5 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (3 of 5)

[redacted]

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	6 **SILVER PPO B**①	7 **SILVER PPO D**①	8 **SILVER PPO C**①	9 **GOLD PPO D**①	10 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 5)

[redacted]

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	11 **GOLD PPO G**①	12 **GOLD PPO C**①	13 **GOLD PPO F**①	14 **GOLD PPO E**①	15 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 5)

[redacted]

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]
Zip: 95361 | County: Stanislaus
Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution: Employee Only	Monthly Premiums prior to Employer Contribution: Additional For Spouse	Your Cost per Pay Period: Employee Only	Your Cost per Pay Period: Additional For Spouse
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 363.96	$ 376.12	$ 363.96	$ 376.12
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 367.63	$ 379.90	$ 367.63	$ 379.90
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 368.63	$ 380.94	$ 368.63	$ 380.94
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 377.10	$ 389.69	$ 377.10	$ 389.69
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 382.05	$ 394.80	$ 382.05	$ 394.80
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 404.44	$ 417.95	$ 404.44	$ 417.95
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 411.99	$ 425.75	$ 411.99	$ 425.75
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 418.20	$ 432.16	$ 418.20	$ 432.16
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 433.05	$ 447.50	$ 433.05	$ 447.50
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 438.84	$ 453.49	$ 438.84	$ 453.49
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 441.70	$ 456.45	$ 441.70	$ 456.45
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 461.97	$ 477.40	$ 461.97	$ 477.40
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 465.07	$ 480.60	$ 465.07	$ 480.60
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 474.41	$ 490.25	$ 474.41	$ 490.25
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 489.61	$ 505.96	$ 489.61	$ 505.96
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 504.50	$ 521.35	$ 504.50	$ 521.35
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 510.79	$ 527.85	$ 510.79	$ 527.85
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 512.35	$ 529.46	$ 512.35	$ 529.46
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 537.12	$ 555.05	$ 537.12	$ 555.05
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 544.84	$ 563.03	$ 544.84	$ 563.03
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 551.47	$ 569.88	$ 551.47	$ 569.88
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 554.22	$ 572.73	$ 554.22	$ 572.73
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 555.50	$ 574.05	$ 555.50	$ 574.05
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 555.50	$ 574.05	$ 555.50	$ 574.05
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 555.91	$ 574.47	$ 555.91	$ 574.47
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 563.81	$ 582.64	$ 563.81	$ 582.64
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 577.70	$ 596.99	$ 577.70	$ 596.99
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 580.24	$ 599.61	$ 580.24	$ 599.61
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 585.55	$ 605.10	$ 585.55	$ 605.10
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 587.04	$ 606.64	$ 587.04	$ 606.64
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 587.82	$ 607.45	$ 587.82	$ 607.45
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 595.23	$ 615.10	$ 595.23	$ 615.10
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 599.54	$ 619.56	$ 599.54	$ 619.56
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 605.04	$ 625.25	$ 605.04	$ 625.25
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 617.31	$ 637.93	$ 617.31	$ 637.93
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 628.69	$ 649.69	$ 628.69	$ 649.69
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 649.89	$ 671.59	$ 649.89	$ 671.59
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 668.93	$ 691.27	$ 668.93	$ 691.27
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 707.61	$ 731.24	$ 707.61	$ 731.24
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 707.61	$ 731.24	$ 707.61	$ 731.24
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 781.30	$ 807.39	$ 781.30	$ 807.39

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution: Employee Only	Monthly Premiums prior to Employer Contribution: Additional For Spouse	Your Cost per Pay Period: Employee Only	Your Cost per Pay Period: Additional For Spouse
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 466.75	$ 482.34	$ 466.75	$ 482.34
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 472.38	$ 488.16	$ 472.38	$ 488.16
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 501.30	$ 518.04	$ 501.30	$ 518.04

Employee Enrollment Worksheet (2 of 10)

[redacted]

Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods.
All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Additional For Spouse	Employee Only	Additional For Spouse
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 507.27	$ 524.21	$ 507.27	$ 524.21
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 508.35	$ 525.32	$ 508.35	$ 525.32
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 511.81	$ 528.90	$ 511.81	$ 528.90
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 545.96	$ 564.19	$ 545.96	$ 564.19
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 549.65	$ 568.01	$ 549.65	$ 568.01
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 589.99	$ 609.69	$ 589.99	$ 609.69
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 595.68	$ 615.57	$ 595.68	$ 615.57
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 616.07	$ 636.64	$ 616.07	$ 636.64
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 622.27	$ 643.04	$ 622.27	$ 643.04
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 661.64	$ 683.74	$ 661.64	$ 683.74
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 668.29	$ 690.61	$ 668.29	$ 690.61
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 769.31	$ 794.99	$ 769.31	$ 794.99

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]

Zip: 95361 | County: Stanislaus

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente	Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑩		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Kaiser Permanente		Kaiser Permanente
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧

Health Plan		Kaiser Permanente		Sutter Health Plus	Kaiser Permanente		Sutter Health Plus		Health Net
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]

Zip: 95361 | County: Stanislaus

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

[redacted]

Zip: 95361 | County: Stanislaus

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Health Net		Kaiser Permanente		Health Net		Sutter Health Plus
Metal Tier & Plan Type	31	**PLATINUM HMO C**	32	**GOLD HMO G**	33	**PLATINUM HMO A**	34	**PLATINUM HMO F**	35	**PLATINUM HMO A**
Network Name		**WholeCare**		**Full**		**Full**		**WholeCare**		**Sutter Health Plus**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay⑬
Lab and X-Ray		$30 Copay		$50 Copay		$40 Copay		100%		$30 Copay per procedure
Specialist Visit		$50 Copay		$50 Copay		$20 Copay		100%		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 4 days max		$750 Copay per day - 4 days max		$500 Copay per admit		$500 Copay per day - 4 days max		$250 Copay per day - 5 days max per admit
Emergency Room		$250 Copay (waived if admitted)		$325 Copay (waived if admitted)		$200 Copay (waived if admitted)		$275 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$30 Copay		$30 Copay		$10 Copay		100%		$20 Copay
Out-Patient Surgery		$500 Copay		$900 Copay		$300 Copay per procedure		$500 Copay		$100 Copay
RX BENEFITS - Generic		$5 Copay⑯		$20 Copay⑯		$5 Copay		100%⑯		$5 Copay④
RX BENEFITS - Formulary Brand		$30 Copay⑯		$50 Copay⑯		$15 Copay		$30 Copay⑯		$20 Copay④
Out-of-Pocket Max-Ind/Fam		$2,700/ $5,400		$7,250 / $14,500		$3,000 / $6,000		$3,300 / $6,600		$4,500 / $9,000②

Health Plan		Sutter Health Plus		Health Net		Health Net		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	36	**PLATINUM HMO B**	37	**PLATINUM HMO E**	38	**PLATINUM HMO H**	39	**GOLD HMO B⑱**	40	**GOLD HMO A⑱**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**CaliforniaCare HMO**		**Select HMO**
HSA Compatible		No		No		No		No		No
Deductible		None		None		None		None		None
DR. OFFICE VISITS		$15 Copay⑬		$30 Copay		100%		$30 Copay		$30 Copay
Lab and X-Ray		$25 Copay per procedure		$30 Copay		100%		$15 Copay㉑		$15 Copay㉑
Specialist Visit		$30 Copay		$50 Copay		100%		$60 Copay		$60 Copay
HOSPITAL SERVICES		$250 Copay per day - 5 days max per admit		$600 Copay per day - 4 days max		$500 Copay per day - 4 days max		$550 Copay per day - 4 days max per admit		$550 Copay per day - 4 days max per admit
Emergency Room		$100 Copay (waived if admitted)		$250 Copay (waived if admitted)		$275 Copay (waived if admitted)		$325 Copay (waived if admitted)		$325 Copay (waived if admitted)
Urgent Care		$15 Copay		$30 Copay		100%		$30 Copay		$30 Copay
Out-Patient Surgery		$100 Copay		$500 Copay		$500 Copay		$500 Copay		$500 Copay
RX BENEFITS - Generic		$5 Copay④		$5 Copay⑯		100%⑯		Level 1 $10 Copay / Level 2 $20 Copay㉒		Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand		$15 Copay④		$30 Copay⑯		$30 Copay⑯		Level 1 $50 Copay / Level 2 $60 Copay㉒		Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam		$3,500 / $7,000②		$2,700/ $5,400		$3,300 / $6,600		$7,250 / $14,500⑳		$7,250 / $14,500⑳

Health Plan		Anthem Blue Cross
Metal Tier & Plan Type	41	**PLATINUM HMO A⑱**
Network Name		**Select HMO**
HSA Compatible		No
Deductible		None
DR. OFFICE VISITS		$20 Copay
Lab and X-Ray		$10 Copay㉑
Specialist Visit		$40 Copay
HOSPITAL SERVICES		$300 Copay per day - 3 days max per admit
Emergency Room		$275 Copay (waived if admitted)
Urgent Care		$20 Copay
Out-Patient Surgery		$250 Copay
RX BENEFITS - Generic		Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand		Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam		$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

[redacted]

Zip: 95361 | County: Stanislaus

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

[redacted]

Zip: 95361 | County: Stanislaus

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

[redacted]

Zip: 95361 | County: Stanislaus

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

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Zip: 95361 | County: Stanislaus

HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

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Zip: 95361 | County: Stanislaus

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 5)

[redacted]

Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution: Employee Only	Additional For Spouse	Additional For Children (0-20)[1]	Your Cost per Pay Period: Employee Only	Additional For Family
1	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 562.92	$ 562.92	$ 354.72	$ 562.92	$ 917.64
2	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 717.06	$ 717.06	$ 451.85	$ 717.06	$ 1,168.91

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution: Employee Only	Additional For Spouse	Additional For Children (0-20)[1]	Your Cost per Pay Period: Employee Only	Additional For Family
3	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 472.99	$ 472.99	$ 298.05	$ 472.99	$ 771.04
4	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 478.69	$ 478.69	$ 301.65	$ 478.69	$ 780.34
5	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 508.00	$ 508.00	$ 320.11	$ 508.00	$ 828.11
6	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 514.04	$ 514.04	$ 323.92	$ 514.04	$ 837.96
7	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 515.14	$ 515.14	$ 324.61	$ 515.14	$ 839.75
8	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 518.65	$ 518.65	$ 326.82	$ 518.65	$ 845.47
9	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 553.26	$ 553.26	$ 348.63	$ 553.26	$ 901.89
10	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 557.00	$ 557.00	$ 350.99	$ 557.00	$ 907.99
11	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 597.87	$ 597.87	$ 376.75	$ 597.87	$ 974.62
12	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 603.64	$ 603.64	$ 380.38	$ 603.64	$ 984.02
13	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 624.30	$ 624.30	$ 393.40	$ 624.30	$ 1,017.70
14	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 630.58	$ 630.58	$ 397.36	$ 630.58	$ 1,027.94
15	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 670.48	$ 670.48	$ 422.50	$ 670.48	$ 1,092.98
16	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 677.22	$ 677.22	$ 426.75	$ 677.22	$ 1,103.97
17	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 779.58	$ 779.58	$ 491.25	$ 779.58	$ 1,270.83

1. Premium reflects 1 child age 0 20.

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (2 of 5)

[redacted]

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan	Anthem Blue Cross	Anthem Blue Cross
Metal Tier & Plan Type	1 **SILVER HMO B①**	2 **GOLD HMO B①**
Network Name	**CaliforniaCare HMO**	**CaliforniaCare HMO**
HSA Compatible	No	No
Deductible	$2,200 / $4,400 (applies to Max OOP)②	None
DR. OFFICE VISITS	$60 Copay (ded waived)	$30 Copay
Lab and X-Ray	$20 Copay (ded waived)④	$15 Copay④
Specialist Visit	$95 Copay (ded waived)	$60 Copay
HOSPITAL SERVICES	55%	$550 Copay per day - 4 days max per admit
Emergency Room	$350 Copay (waived if admitted) - 55%	$325 Copay (waived if admitted)
Urgent Care	$60 Copay (ded waived)	$30 Copay
Out-Patient Surgery	55%	$500 Copay
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)⑤	Level 1 $10 Copay / Level 2 $20 Copay⑤
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay⑤	Level 1 $50 Copay / Level 2 $60 Copay⑤
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,250 / $14,500③

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	3 **BRONZE PPO D①**	4 **BRONZE PPO B①**	5 **BRONZE PPO C①**	6 **BRONZE PPO A①**	7 **SILVER PPO E①**
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (3 of 5)

[redacted]

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	8 **SILVER PPO B①**	9 **SILVER PPO D①**	10 **SILVER PPO C①**	11 **GOLD PPO D①**	12 **GOLD PPO B①**
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Employee Enrollment Worksheet (4 of 5)

[redacted]

PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	13 **GOLD PPO G**①	14 **GOLD PPO C**①	15 **GOLD PPO F**①	16 **GOLD PPO E**①	17 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 5)

[redacted]

HMO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

⑤ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.

Employee Enrollment Worksheet (1 of 10)

[redacted]

Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

Platinum/Gold/Silver/Bronze Plan Options & Rates

HMO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution: Employee Only	Additional For Spouse	Additional For Children (0-20)[1]	Your Cost per Pay Period: Employee Only	Additional For Family
1	SUTTER HEALTH PLUS	HMO	BRONZE HMO A	SUTTER HEALTH PLUS	$ 376.12	$ 373.69	$ 464.82	$ 376.12	$ 838.51
2	KAISER PERMANENTE	HSA/HMO	BRONZE HMO C	FULL	$ 379.90	$ 377.45	$ 498.04	$ 379.90	$ 875.49
3	KAISER PERMANENTE	HMO	BRONZE HMO B	FULL	$ 380.94	$ 378.48	$ 499.34	$ 380.94	$ 877.82
4	KAISER PERMANENTE	HMO	BRONZE HMO A	FULL	$ 389.69	$ 387.17	$ 510.14	$ 389.69	$ 897.31
5	SUTTER HEALTH PLUS	HSA/HMO	BRONZE HMO B	SUTTER HEALTH PLUS	$ 394.80	$ 392.25	$ 487.92	$ 394.80	$ 880.17
6	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 417.95	$ 415.25	$ 545.06	$ 417.95	$ 960.31
7	SUTTER HEALTH PLUS	HSA/HMO	SILVER HMO C	SUTTER HEALTH PLUS	$ 425.75	$ 422.99	$ 526.16	$ 425.75	$ 949.15
8	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 432.16	$ 429.37	$ 562.64	$ 432.16	$ 992.01
9	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 447.50	$ 444.61	$ 581.60	$ 447.50	$ 1,026.21
10	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 453.49	$ 450.56	$ 589.00	$ 453.49	$ 1,039.56
11	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 456.45	$ 453.50	$ 592.66	$ 456.45	$ 1,046.16
12	SUTTER HEALTH PLUS	HMO	SILVER HMO B	SUTTER HEALTH PLUS	$ 477.40	$ 474.31	$ 590.00	$ 477.40	$ 1,064.31
13	KAISER PERMANENTE	HSA/HMO	GOLD HMO E	FULL	$ 480.60	$ 477.49	$ 622.50	$ 480.60	$ 1,099.99
14	SUTTER HEALTH PLUS	HSA/HMO	GOLD HMO C	SUTTER HEALTH PLUS	$ 490.25	$ 487.08	$ 605.88	$ 490.25	$ 1,092.96
15	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 505.96	$ 502.69	$ 625.30	$ 505.96	$ 1,127.99
16	HEALTH NET	HMO	SILVER HMO D	FULL	$ 521.35	$ 517.98	$ 644.32	$ 521.35	$ 1,162.30
17	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 527.85	$ 524.44	$ 680.88	$ 527.85	$ 1,205.32
18	SUTTER HEALTH PLUS	HMO	GOLD HMO A	SUTTER HEALTH PLUS	$ 529.46	$ 526.03	$ 654.34	$ 529.46	$ 1,180.37
19	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 555.05	$ 551.46	$ 714.50	$ 555.05	$ 1,265.96
20	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 563.03	$ 559.39	$ 695.84	$ 563.03	$ 1,255.23
21	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 569.88	$ 566.20	$ 704.30	$ 569.88	$ 1,270.50
22	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 572.73	$ 569.03	$ 736.36	$ 572.73	$ 1,305.39
23	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 574.05	$ 570.34	$ 709.44	$ 574.05	$ 1,279.78
24	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 574.05	$ 570.34	$ 709.44	$ 574.05	$ 1,279.78
25	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 574.47	$ 570.76	$ 709.98	$ 574.47	$ 1,280.74
26	SUTTER HEALTH PLUS	HMO	GOLD HMO B	SUTTER HEALTH PLUS	$ 582.64	$ 578.87	$ 720.06	$ 582.64	$ 1,298.93
27	HEALTH NET	HMO	GOLD HMO F	FULL	$ 596.99	$ 593.13	$ 737.80	$ 596.99	$ 1,330.93
28	KAISER PERMANENTE	HMO	PLATINUM HMO C	FULL	$ 599.61	$ 595.74	$ 769.58	$ 599.61	$ 1,365.32
29	HEALTH NET	HMO	GOLD HMO E	FULL	$ 605.10	$ 601.19	$ 747.82	$ 605.10	$ 1,349.01
30	KAISER PERMANENTE	HMO	PLATINUM HMO B	FULL	$ 606.64	$ 602.72	$ 778.26	$ 606.64	$ 1,380.98
31	HEALTH NET	HMO	PLATINUM HMO C	WHOLECARE	$ 607.45	$ 603.52	$ 750.72	$ 607.45	$ 1,354.24
32	HEALTH NET	HMO	GOLD HMO G	FULL	$ 615.10	$ 611.13	$ 760.18	$ 615.10	$ 1,371.31
33	KAISER PERMANENTE	HMO	PLATINUM HMO A	FULL	$ 619.56	$ 615.55	$ 794.22	$ 619.56	$ 1,409.77
34	HEALTH NET	HMO	PLATINUM HMO F	WHOLECARE	$ 625.25	$ 621.21	$ 772.72	$ 625.25	$ 1,393.93
35	SUTTER HEALTH PLUS	HMO	PLATINUM HMO A	SUTTER HEALTH PLUS	$ 637.93	$ 633.80	$ 788.38	$ 637.93	$ 1,422.18
36	SUTTER HEALTH PLUS	HMO	PLATINUM HMO B	SUTTER HEALTH PLUS	$ 649.69	$ 645.49	$ 802.92	$ 649.69	$ 1,448.41
37	HEALTH NET	HMO	PLATINUM HMO E	FULL	$ 671.59	$ 667.25	$ 830.00	$ 671.59	$ 1,497.25
38	HEALTH NET	HMO	PLATINUM HMO H	FULL	$ 691.27	$ 686.80	$ 854.32	$ 691.27	$ 1,541.12
39	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 731.24	$ 726.51	$ 903.70	$ 731.24	$ 1,630.21
40	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 731.24	$ 726.51	$ 903.70	$ 731.24	$ 1,630.21
41	ANTHEM BLUE CROSS	HMO	PLATINUM HMO A	SELECT HMO	$ 807.39	$ 802.17	$ 997.82	$ 807.39	$ 1,799.99

Platinum/Gold/Silver/Bronze Plan Options & Rates

PPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution: Employee Only	Additional For Spouse	Additional For Children (0-20)[1]	Your Cost per Pay Period: Employee Only	Additional For Family
42	ANTHEM BLUE CROSS	PPO	BRONZE PPO D	SELECT PPO	$ 482.34	$ 479.22	$ 596.10	$ 482.34	$ 1,075.32
43	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO B	SELECT PPO	$ 488.16	$ 485.00	$ 603.30	$ 488.16	$ 1,088.30

Employee Enrollment Worksheet (2 of 10)

[redacted]

Rating Area: 1 | Rating Zip: 95252 | Rating County: Calaveras

Have we correctly listed your **Age** and **County** of **Residence** above? ☐Yes ☐No (If no, your quoted premium may be incorrect. Please notify your Employer.)

The premiums listed under "Your Cost" illustrate the cost to you *before* your employer has made their contribution based on 12 Pay Periods. All family members must enroll in the same Plan.

Your Employer has agreed to contribute:
For Employee
For Dependent

	Health Plan	Type	Plan Name	Network	Employee Only	Additional For Spouse	Additional For Children (0-20)[1]	Employee Only	Additional For Family
44	ANTHEM BLUE CROSS	PPO	BRONZE PPO C	PRUDENT BUYER	$ 518.04	$ 514.69	$ 640.22	$ 518.04	$ 1,154.91
45	ANTHEM BLUE CROSS	HSA/PPO	BRONZE PPO A	PRUDENT BUYER	$ 524.21	$ 520.82	$ 647.84	$ 524.21	$ 1,168.66
46	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO E	SELECT PPO	$ 525.32	$ 521.93	$ 649.22	$ 525.32	$ 1,171.15
47	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 528.90	$ 525.48	$ 653.64	$ 528.90	$ 1,179.12
48	ANTHEM BLUE CROSS	HSA/PPO	SILVER PPO D	PRUDENT BUYER	$ 564.19	$ 560.55	$ 697.26	$ 564.19	$ 1,257.81
49	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 568.01	$ 564.34	$ 701.98	$ 568.01	$ 1,266.32
50	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 609.69	$ 605.75	$ 753.50	$ 609.69	$ 1,359.25
51	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 615.57	$ 611.59	$ 760.76	$ 615.57	$ 1,372.35
52	ANTHEM BLUE CROSS	PPO	GOLD PPO G	SELECT PPO	$ 636.64	$ 632.53	$ 786.80	$ 636.64	$ 1,419.33
53	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 643.04	$ 638.89	$ 794.72	$ 643.04	$ 1,433.61
54	ANTHEM BLUE CROSS	PPO	GOLD PPO F	PRUDENT BUYER	$ 683.74	$ 679.32	$ 845.00	$ 683.74	$ 1,524.32
55	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 690.61	$ 686.14	$ 853.50	$ 690.61	$ 1,539.64
56	ANTHEM BLUE CROSS	PPO	PLATINUM PPO A	PRUDENT BUYER	$ 794.99	$ 789.86	$ 982.50	$ 794.99	$ 1,772.36

1. Premium reflects 2 children age 0 20.

Note: Rates are guaranteed for 12 months. We assume no liability for rate or benefit discrepancies. See Evidence of Coverage and/or Summary of Benefits and Coverage (www.calchoice.com/Public/Forms and click on Documents) for additional benefits.
Each plan offered in the CaliforniaChoice Program meets the requirements of the Affordable Care Act (ACA).

Employee Enrollment Worksheet (3 of 10)

[redacted]

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Sutter Health Plus		Kaiser Permanente		Kaiser Permanente		Kaiser Permanente		Sutter Health Plus
Metal Tier & Plan Type	1	**BRONZE HMO A**	2	**BRONZE HMO C**	3	**BRONZE HMO B**	4	**BRONZE HMO A**	5	**BRONZE HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Sutter Health Plus**
HSA Compatible		No		Yes		No		No		Yes
Deductible		$6,300 / $12,600 (applies to Max OOP)①		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)⑦		$5,400 / $10,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$6,300 / $12,600 (applies to Max OOP)⑪		$7,050 / $14,100 (comb. Med/Rx ded; applies to Max OOP)①
DR. OFFICE VISITS		$60 Copay③		100%		$60 Copay⑨		$60 Copay⑫		100%⑬
Lab and X-Ray		60%		100%		50%		60%		100%
Specialist Visit		$95 Copay⑥		100%		$80 Copay⑨		$95 Copay⑫		100%
HOSPITAL SERVICES		60%		100%		50%		60%		100%
Emergency Room		60%		100%		50%		60%		100%
Urgent Care		$60 Copay⑥		100%		$60 Copay⑨		$60 Copay⑫		100%
Out-Patient Surgery		60%		100%		50%		60%		100%
RX BENEFITS - Generic		$500 / $1,000 Ded - $17 Copay④		100% (comb. Med/Rx ded)		$20 Copay (ded waived)		$500 / $1,000 Ded $17 Copay		100% (comb. Med/Rx ded)④
RX BENEFITS - Formulary Brand		$500 / $1,000 Ded - 60% (up to $500 per prescription)⑤		100% (comb. Med/Rx ded)		50% (up to $500 per prescription; comb. Med/Rx ded) ⑩		$500 / $1,000 Ded 60% (up to $500 per prescription)⑱		100% (comb. Med/Rx ded)④
Out-of-Pocket Max-Ind/Fam		$9,100 / $18,200②		$7,050 / $14,100		$8,600 / $17,200⑧		$9,100 / $18,200⑧		$7,050 / $14,100②
Health Plan		**Kaiser Permanente**		**Sutter Health Plus**		**Kaiser Permanente**		**Kaiser Permanente**		**Kaiser Permanente**
Metal Tier & Plan Type	6	**SILVER HMO D**	7	**SILVER HMO C**	8	**SILVER HMO E**	9	**SILVER HMO A**	10	**SILVER HMO C**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Full**		**Full**
HSA Compatible		Yes		Yes		No		No		No
Deductible		$2,850 / $3,200 / $5,700 (comb. Med/Rx ded; applies to Max OOP)⑭		$2,800 / $3,200 / $5,600 (comb. Med/Rx ded; applies to Max OOP)①		$2,950 / $5,900 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,300 / $4,600 (applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)⑦
DR. OFFICE VISITS		75%		$35 Copay⑬		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Lab and X-Ray		75%		$35 Copay per procedure		$75 Copay		$75 Copay (ded waived)		$90 Copay (ded waived)
Specialist Visit		75%		$50 Copay		$100 Copay (ded waived)		$100 Copay (ded waived)		$90 Copay (ded waived)
HOSPITAL SERVICES		75%		75%		55%		55%		65%
Emergency Room		75%		75%		55%		55%		65%
Urgent Care		75%		$35 Copay		$65 Copay (ded waived)		$65 Copay (ded waived)		$55 Copay (ded waived)
Out-Patient Surgery		75%		75%		55%		55%		65%
RX BENEFITS - Generic		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$20 Copay (comb. Med/Rx ded)④		$20 Copay (ded waived)		$20 Copay (ded waived)		$19 Copay (ded waived)
RX BENEFITS - Formulary Brand		75% (up to $250 per prescription; comb. Med/Rx ded)⑩		$40 Copay (comb. Med/Rx ded)④		$100 Copay (comb. Med/Rx ded)		$500/ $1,000 Ded - $100 Copay		$300 / $600 Ded - $85 Copay
Out-of-Pocket Max-Ind/Fam		$7,500 / $15,000⑧		$7,200 / $14,400②		$9,100 / $18,200⑧		$8,750 / $17,500⑧		$8,750 / $17,500⑧
Health Plan		**Kaiser Permanente**		**Sutter Health Plus**		**Kaiser Permanente**		**Sutter Health Plus**		**Health Net**
Metal Tier & Plan Type	11	**SILVER HMO B**	12	**SILVER HMO B**	13	**GOLD HMO E**	14	**GOLD HMO C**	15	**SILVER HMO A**
Network Name		**Full**		**Sutter Health Plus**		**Full**		**Sutter Health Plus**		**WholeCare**
HSA Compatible		No		No		Yes		Yes		No
Deductible		$1,900 / $3,800 (comb. Med/Rx ded; applies to Max OOP)⑦		$2,500 / $5,000 (applies to Max OOP)①		$1,750 / $3,200 / $3,500 (comb. Med/Rx ded; applies to Max OOP)⑮		$1,600 / $3,200 / $3,200 (comb. Med/Rx ded; applies to Max OOP)①		None
DR. OFFICE VISITS		$65 Copay (ded waived)		$55 Copay (ded waived)⑬		85%		80%⑬		$55 Copay
Lab and X-Ray		$75 Copay (ded waived)		$90 Copay per procedure (ded waived)		85%		80%		$60 Copay
Specialist Visit		$100 Copay (ded waived)		$90 Copay (ded waived)		85%		80%		$90 Copay
HOSPITAL SERVICES		55%		65%		85%		80%		50%
Emergency Room		55%		65%		85%		80%		50%
Urgent Care		$65 Copay (ded waived)		$55 Copay (ded waived)		85%		80%		$55 Copay
Out-Patient Surgery		55%		65%		85%		80%		50%
RX BENEFITS - Generic		$20 Copay (ded waived)		$19 Copay (ded waived)④		$15 Copay (comb. Med/Rx ded)		$15 copay (comb. Med/Rx ded)④		$20 Copay (ded waived)⑯
RX BENEFITS - Formulary Brand		$100 Copay (ded waived)		$300 / $600 Ded - $85 Copay④		$45 Copay (comb. Med/Rx ded)		$50 copay (comb. Med/Rx ded)④		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰
Out-of-Pocket Max-Ind/Fam		$8,750 / $17,500⑧		$8,750 / $17,500②		$3,700 / $7,400⑧		$6,000 / $12,000②		$9,450 / $18,900

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (4 of 10)

[redacted]

HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan		Health Net		Kaiser Permanente		Sutter Health Plus		Kaiser Permanente		Health Net
Metal Tier & Plan Type	16	**SILVER HMO D**	17	**GOLD HMO D**	18	**GOLD HMO A**	19	**GOLD HMO B**	20	**GOLD HMO B**
Network Name		**Full**		**Full**		**Sutter Health Plus**		**Full**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		$1,000 / $2,000 (applies to Max OOP)⑦		$1,500 / $3,000 (applies to Max OOP)①		$250 / $500 (applies to Max OOP)⑦		None
DR. OFFICE VISITS		$55 Copay		$40 Copay (ded waived)		$30 Copay⑬		$35 Copay (ded waived)		$40 Copay
Lab and X-Ray		$60 Copay		$60 Copay (ded waived)		$50 Copay per procedure		$55 Copay (ded waived)		$50 Copay
Specialist Visit		$90 Copay		$60 Copay (ded waived)		$50 Copay		$55 Copay (ded waived)		$60 Copay
HOSPITAL SERVICES		50%		$600 Copay per day - 5 days max		80%		$600 Copay per day, 5 days max		$750 Copay per day - 5 days max
Emergency Room		50%		$350 Copay (ded waived; waived if admitted)		$200 Copay (waived if admitted)		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)
Urgent Care		$55 Copay		$40 Copay (ded waived)		$30 Copay		$35 Copay (ded waived)		$40 Copay
Out-Patient Surgery		50%		$350 Copay per procedure (ded waived)		80%		$335 Copay per procedure		$1,200 Copay
RX BENEFITS - Generic		$20 Copay (ded waived)⑯		$20 Copay (ded waived)		$15 copay (overall ded waived)④		$15 Copay (overall ded waived)		$15 Copay⑯
RX BENEFITS - Formulary Brand		$750 / $1,500 Ded - 50% (up to $250 per prescription)⑰		$250 / $500 Ded - $50 Copay		$30 copay (overall ded waived)④		$40 Copay (overall ded waived)		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$9,450 / $18,900		$7,800 / $15,600⑧		$5,000 / $10,000②		$7,800 / $15,600⑧		$7,500 / $15,000

Health Plan		Health Net		Kaiser Permanente		Anthem Blue Cross		Anthem Blue Cross		Health Net
Metal Tier & Plan Type	21	**GOLD HMO C**	22	**GOLD HMO C**	23	**SILVER HMO A⑱**	24	**SILVER HMO B⑱**	25	**GOLD HMO A**
Network Name		**WholeCare**		**Full**		**Select HMO**		**CaliforniaCare HMO**		**WholeCare**
HSA Compatible		No		No		No		No		No
Deductible		None		None		$2,200 / $4,400 (applies to Max OOP)⑲		$2,200 / $4,400 (applies to Max OOP)⑲		None
DR. OFFICE VISITS		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Lab and X-Ray		$50 Copay		$40 Copay		$20 Copay (ded waived)㉑		$20 Copay (ded waived)㉑		$40 Copay
Specialist Visit		$55 Copay		$60 Copay		$95 Copay (ded waived)		$95 Copay (ded waived)		$50 Copay
HOSPITAL SERVICES		$750 Copay per day - 4 days max		$600 Copay per day - 5 days max		55%		55%		$750 Copay per day - 4 days max
Emergency Room		$325 Copay (waived if admitted)		$350 Copay (waived if admitted)		$350 Copay (waived if admitted) - 55%		$350 Copay (waived if admitted) - 55%		$325 Copay (waived if admitted)
Urgent Care		$35 Copay		$35 Copay		$60 Copay (ded waived)		$60 Copay (ded waived)		$30 Copay
Out-Patient Surgery		$1,200 Copay		$320 Copay per procedure		55%		55%		$900 Copay
RX BENEFITS - Generic		$15 Copay⑯		$15 Copay		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		Level 1 $10 Copay / Level 2 $20 Copay (ded waived)㉒		$20 Copay⑯
RX BENEFITS - Formulary Brand		$50 Copay⑯		$50 Copay		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay㉒		$50 Copay⑯
Out-of-Pocket Max-Ind/Fam		$7,350 / $14,700		$7,700 / $15,400⑧		$9,100 / $18,200⑳		$9,100 / $18,200⑳		$7,250 / $14,500

Health Plan		Sutter Health Plus		Health Net		Kaiser Permanente		Health Net		Kaiser Permanente
Metal Tier & Plan Type	26	**GOLD HMO B**	27	**GOLD HMO F**	28	**PLATINUM HMO C**	29	**GOLD HMO E**	30	**PLATINUM HMO B**
Network Name		**Sutter Health Plus**		**Full**		**Full**		**Full**		**Full**
HSA Compatible		No		No		No		No		No
Deductible		$250 / $500 (applies to Max OOP)①		None		$250 / $500 (comb. Med/Rx ded; applies to Max OOP)⑦		None		None
DR. OFFICE VISITS		$35 Copay (ded waived)⑬		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Lab and X-Ray		$55 Copay per procedure (ded waived)		$50 Copay		$50 Copay (ded waived)		$50 Copay		$30 Copay
Specialist Visit		$55 Copay (ded waived)		$60 Copay		$50 Copay (ded waived)		$55 Copay		$30 Copay
HOSPITAL SERVICES		$600 Copay per day - 5 days max per admit		$750 Copay per day - 5 days max		$500 Copay per admit		$750 Copay per day - 4 days max		$250 Copay per day - 5 days max
Emergency Room		$250 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (ded waived; waived if admitted)		$325 Copay (waived if admitted)		$150 Copay (waived if admitted)
Urgent Care		$35 Copay (ded waived)		$40 Copay		$30 Copay (ded waived)		$35 Copay		$20 Copay
Out-Patient Surgery		$300 Copay		$1,200 Copay		$300 Copay (ded waived) per procedure		$1,200 Copay		$125 Copay per procedure
RX BENEFITS - Generic		$15 Copay (overall ded waived)④		$15 Copay⑯		$10 Copay (ded waived)		$15 Copay⑯		$5 Copay
RX BENEFITS - Formulary Brand		$40 Copay (overall ded waived)④		$50 Copay⑯		$20 Copay (ded waived)		$50 Copay⑯		$20 Copay
Out-of-Pocket Max-Ind/Fam		$7,800 / $15,600②		$7,500 / $15,000		$3,000 / $6,000⑧		$7,350 / $14,700		$4,500 / $9,000

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (5 of 10)

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HMO Summary of Benefits

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in network through your Primary Care Physicians (PCP).

Health Plan	Health Net	Health Net	Kaiser Permanente	Health Net	Sutter Health Plus
Metal Tier & Plan Type	31 **PLATINUM HMO C**	32 **GOLD HMO G**	33 **PLATINUM HMO A**	34 **PLATINUM HMO F**	35 **PLATINUM HMO A**
Network Name	**WholeCare**	**Full**	**Full**	**WholeCare**	**Sutter Health Plus**
HSA Compatible	No	No	No	No	No
Deductible	None	None	None	None	None
DR. OFFICE VISITS	$30 Copay	$30 Copay	$10 Copay	100%	$20 Copay⑬
Lab and X-Ray	$30 Copay	$50 Copay	$40 Copay	100%	$30 Copay per procedure
Specialist Visit	$50 Copay	$50 Copay	$20 Copay	100%	$30 Copay
HOSPITAL SERVICES	$600 Copay per day - 4 days max	$750 Copay per day - 4 days max	$500 Copay per admit	$500 Copay per day - 4 days max	$250 Copay per day - 5 days max per admit
Emergency Room	$250 Copay (waived if admitted)	$325 Copay (waived if admitted)	$200 Copay (waived if admitted)	$275 Copay (waived if admitted)	$150 Copay (waived if admitted)
Urgent Care	$30 Copay	$30 Copay	$10 Copay	100%	$20 Copay
Out-Patient Surgery	$500 Copay	$900 Copay	$300 Copay per procedure	$500 Copay	$100 Copay
RX BENEFITS - Generic	$5 Copay⑯	$20 Copay⑯	$5 Copay	100%⑯	$5 Copay④
RX BENEFITS - Formulary Brand	$30 Copay⑯	$50 Copay⑯	$15 Copay	$30 Copay⑯	$20 Copay④
Out-of-Pocket Max-Ind/Fam	$2,700/ $5,400	$7,250 / $14,500	$3,000 / $6,000	$3,300 / $6,600	$4,500 / $9,000②

Health Plan	Sutter Health Plus	Health Net	Health Net	Anthem Blue Cross	Anthem Blue Cross
Metal Tier & Plan Type	36 **PLATINUM HMO B**	37 **PLATINUM HMO E**	38 **PLATINUM HMO H**	39 **GOLD HMO B⑱**	40 **GOLD HMO A⑱**
Network Name	**Sutter Health Plus**	**Full**	**Full**	**CaliforniaCare HMO**	**Select HMO**
HSA Compatible	No	No	No	No	No
Deductible	None	None	None	None	None
DR. OFFICE VISITS	$15 Copay⑬	$30 Copay	100%	$30 Copay	$30 Copay
Lab and X-Ray	$25 Copay per procedure	$30 Copay	100%	$15 Copay㉑	$15 Copay㉑
Specialist Visit	$30 Copay	$50 Copay	100%	$60 Copay	$60 Copay
HOSPITAL SERVICES	$250 Copay per day - 5 days max per admit	$600 Copay per day - 4 days max	$500 Copay per day - 4 days max	$550 Copay per day - 4 days max per admit	$550 Copay per day - 4 days max per admit
Emergency Room	$100 Copay (waived if admitted)	$250 Copay (waived if admitted)	$275 Copay (waived if admitted)	$325 Copay (waived if admitted)	$325 Copay (waived if admitted)
Urgent Care	$15 Copay	$30 Copay	100%	$30 Copay	$30 Copay
Out-Patient Surgery	$100 Copay	$500 Copay	$500 Copay	$500 Copay	$500 Copay
RX BENEFITS - Generic	$5 Copay④	$5 Copay⑯	100%⑯	Level 1 $10 Copay / Level 2 $20 Copay㉒	Level 1 $10 Copay / Level 2 $20 Copay㉒
RX BENEFITS - Formulary Brand	$15 Copay④	$30 Copay⑯	$30 Copay⑯	Level 1 $50 Copay / Level 2 $60 Copay㉒	Level 1 $50 Copay / Level 2 $60 Copay㉒
Out-of-Pocket Max-Ind/Fam	$3,500 / $7,000②	$2,700/ $5,400	$3,300 / $6,600	$7,250 / $14,500⑳	$7,250 / $14,500⑳

Health Plan	Anthem Blue Cross
Metal Tier & Plan Type	41 **PLATINUM HMO A⑱**
Network Name	**Select HMO**
HSA Compatible	No
Deductible	None
DR. OFFICE VISITS	$20 Copay
Lab and X-Ray	$10 Copay㉑
Specialist Visit	$40 Copay
HOSPITAL SERVICES	$300 Copay per day - 3 days max per admit
Emergency Room	$275 Copay (waived if admitted)
Urgent Care	$20 Copay
Out-Patient Surgery	$250 Copay
RX BENEFITS - Generic	Level 1 $5 Copay / Level 2 $15 Copay㉒
RX BENEFITS - Formulary Brand	Level 1 $20 Copay / Level 2 $30 Copay㉒
Out-of-Pocket Max-Ind/Fam	$2,500 / $5,000⑳

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (6 of 10)

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PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	42 **BRONZE PPO D**①	43 **BRONZE PPO B**①	44 **BRONZE PPO C**①	45 **BRONZE PPO A**①	46 **SILVER PPO E**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$6,000 / $12,000 (applies to Max OOP)②	$6,250 / $12,500 (comb. Med/Rx ded; applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	$65 Copay	65%	$65 Copay	65%	65%
Lab and X-Ray	60%	65%	60%	65%	65%
Specialist Visit	$85 Copay	65%	$85 Copay	65%	65%
HOSPITAL SERVICES	60%	65%	60%	65%	65%
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	$65 Copay	65%	$65 Copay	65%	65%
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 65%
RX BENEFITS - Generic	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $20 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $20 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥
RX BENEFITS - Formulary Brand	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	$650 / $1,300 Ded - Level 1 $90 Copay / Level 2 $100 Copay④	Level 1 $90 Copay / Level 2 $100 Copay (comb. Med/Rx ded)⑥	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥
Out-of-Pocket Max-Ind/Fam	$8,500 / $17,000③	$7,350 / $14,700③	$8,500 / $17,000③	$7,350 / $14,700③	$7,700 / $15,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	Yes	Yes
Deductible	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$12,000 / $24,000 (applies to Max OOP)②	$12,500 / $25,000 (comb. Med/Rx ded; applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 60%	65%	$250 Copay (waived if admitted) - 60%	65%	65%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$17,000 / $34,000③	$14,700 / $29,400③	$17,000 / $34,000③	$14,700 / $29,400③	$15,400 / $30,800③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (7 of 10)

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PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	47 **SILVER PPO B**①	48 **SILVER PPO D**①	49 **SILVER PPO C**①	50 **GOLD PPO D**①	51 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Select PPO**	**Select PPO**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,700 / $3,400 (applies to Max OOP)②	$2,000 / $3,200 / $4,000 (comb. Med/Rx ded; applies to Max OOP)②	$1,700 / $3,400 (applies to Max OOP)②	$1,500 / $3,000 (applies to Max OOP)②	$1,000 / $3,000 (applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	65%	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	65%	$95 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	65%	60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$50 Copay (ded waived)	65%	$50 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Out-Patient Surgery	$250 Copay per admit - 60%	$250 Copay per admit - 65%	$250 Copay per admit - 60%	$250 Copay per admit - 75%	$250 Copay per admit - 75%
RX BENEFITS - Generic	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $15 Copay / Level 2 $20 Copay (comb. Med/Rx ded)⑥	Level 1 $15 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	Level 1 $70 Copay / Level 2 $80 Copay (comb. Med/Rx ded)⑥	$300 / $600 Ded - Level 1 $70 Copay / Level 2 $80 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	$250 / $500 Ded - Level 1 $50 Copay / Level 2 $60 Copay④
Out-of-Pocket Max-Ind/Fam	$9,100 / $18,200③	$7,700 / $15,400③	$9,100 / $18,200③	$6,600 / $13,200③	$7,800 / $15,600③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	Yes	No	No	No
Deductible	$3,400 / $6,800 (applies to Max OOP)②	$4,000 / $6,400 / $8,000 (comb. Med/Rx ded; applies to Max OOP)②	$3,400 / $6,800 (applies to Max OOP)②	$3,000 / $6,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$300 Copay (waived if admitted) - 60%	65%	$300 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$18,200 / $36,400③	$15,400 / $30,800③	$18,200 / $36,400③	$13,200 / $26,400③	$15,600 / $31,200③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (8 of 10)

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PPO Summary of Benefits

A PPO provides benefits within the health plan's network of doctors with the option of going out of network at higher cost.

Health Plan	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross	Anthem Blue Cross
IN NETWORK					
Metal Tier & Plan Type	52 **GOLD PPO G**①	53 **GOLD PPO C**①	54 **GOLD PPO F**①	55 **GOLD PPO E**①	56 **PLATINUM PPO A**①
Network Name	**Select PPO**	**Select PPO**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**	**Prudent Buyer - Small Group**
HSA Compatible	No	No	No	No	No
Deductible	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	$500 / $1,500 (applies to Max OOP)②	None
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$10 Copay
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)	$35 Copay
HOSPITAL SERVICES	80%	80%	80%	80%	90%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)	$10 Copay
Out-Patient Surgery	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$250 Copay per admit - 80%	$200 Copay per admit - 90%
RX BENEFITS - Generic	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (ded waived)④	Level 1 $10 Copay / Level 2 $20 Copay (overall ded waived)④	Level 1 $5 Copay / Level 2 $15 Copay④
RX BENEFITS - Formulary Brand	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	$150 / $300 Ded - Level 1 $50 Copay / Level 2 $60 Copay④	Level 1 $50 Copay / Level 2 $60 Copay (overall ded waived)④	Level 1 $15 Copay / Level 2 $25 Copay④
Out-of-Pocket Max-Ind/Fam	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$7,700 / $15,400③	$8,000 / $16,000③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②	$2,000 / $4,000 (applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%	50%	50%
Lab and X-Ray	50%	50%	50%	50%	50%
Specialist Visit	50%	50%	50%	50%	50%
HOSPITAL SERVICES	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤	50% (up to $650 per day)⑤
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$500 Copay (waived if admitted) - 90%
Urgent Care	50%	50%	50%	50%	50%
Out-Patient Surgery	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤	50% (up to $380 per admit)⑤
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$15,400 / $30,800③	$16,000 / $32,000③

Co insurances listed are the Plan responsibility and co payments listed are Member responsibility.
Pediatric Dental and Vision benefits are included in all health plans.

Employee Enrollment Worksheet (9 of 10)

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HMO Plans

① All services are subject to the deductible unless otherwise stated. For members who are not part of a family plan, once the member meets the "single" deductible, if applicable, the member is responsible for the specific cost sharing until the "single" OOPM is met. Once the "single" OOPM is met, Sutter Health Plus pays all costs for covered services. For members who are part of a family plan, once an individual member of the family meets the "individual family member" deductible, if applicable, only the individual member is responsible for the specific cost sharing until either that member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once the family as a whole meets the "family" deductible, if applicable, all members of the family are responsible for the specific cost sharing, regardless of whether each family member met their "individual family member" deductible, until either an individual member meets the "individual family member" OOPM, or until the family as a whole meets the "family" OOPM, whichever comes first. Once an individual member of the family meets the "individual family member" OOPM, Sutter Health Plus pays all costs for covered services only for that individual member. Once the family as a whole meets the "family" OOPM, Sutter Health Plus pays all costs for covered services for all family members, regardless of whether each family member met their "individual family member" OOPM. For high deductible health plans (HDHPs), in a "family" plan, an "individual family member" deductible must be the higher of the specified "single" deductible amount or the Internal Revenue Service (IRS) minimum of $3,200 for 2024 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 When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits. 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.

④ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met.

⑤ Cost sharing applies per prescription for up to a 30 day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Except for specialty drugs, up to a 100 day supply is available, at twice the 30 day retail copayment price, through the mail order pharmacy. Specialty drugs are available for up to a 30 day supply through the specialty pharmacy. Cost sharing for a 12 month supply of FDA approved, self administered hormonal contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost. Member cost sharing for oral anti cancer drugs shall not exceed $250 per prescription for up to a 30 day supply. For HDHP plans, this $250 maximum will not apply until after the deductible is met. Maximum member responsibility.

⑥ When outpatient benefits have cost sharing that includes "deductible waived for 1st 3 non preventive visits", the deductible is waived for the first three non preventive visits combined, which may include office visits or urgent care visits.

⑦ All services are subject to the deductible unless otherwise stated. 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.

⑧ 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.

⑨ Deductible is waived for first three visits (combined for primary care, specialist, urgent care, and individual mental/behavioral health and substance use disorder services).

⑩ 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 Deductible is waived for first three visits (combined for primary care, specialist and urgent care).

⑬ Cost sharing also applies to other practitioner office visits. These include therapy visits, and other office visits not provided by either primary care physicians or specialists, or visits not specified in another benefit category such as Sutter Walk in Care visits.

⑭ All services are subject to the deductible unless otherwise stated. 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. $2,850 Self only enrollment, $3,200 for any one member within a Family enrollment. $5,700 for an entire Family. Does not apply to preventive care.

⑮ All services are subject to the deductible unless otherwise stated. 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. $1,750 Self only enrollment, $3,200 for any one member within a Family enrollment. $3,500 for an entire Family. Does not apply to preventive care.

⑯ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non formulary; Tier 4: Specialty. See plan specific EOC for information regarding preventive drugs and womens contraceptives. Maximum member responsibility.

⑱ This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/Public/Forms) or the plan specific EOC or COI for information on Infertility benefits.

⑲ 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.

Employee Enrollment Worksheet (10 of 10)

[redacted]

Notes (cont.)

⑳ 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.

㉑ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

㉒ 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.

PPO Plans

① This plan includes certain Infertility benefits, please see the CaliforniaChoice Benefit Summaries (www.calchoice.com/DownloadForms.aspx) or the plan specific EOC or COI for information on Infertility benefits. 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.

② 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.

③ Family Out of Pocket Limit: For any given Member, the Out of Pocket Limit is met either after he/she meets their individual Out of Pocket Limit, or after the entire family Out of Pocket Limit is met. The family Out of Pocket Limit can be met by any combination of amounts from any Member; however, no one Member may contribute any more than his/her individual Out of Pocket Limit toward the family Out of Pocket Limit.

④ 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.

⑤ Amount listed is maximum paid by Anthem.

⑥ 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. Deductible is waived for drugs on the PreventiveRx Plus drug list.