WIRELESS WATCHDOGS L L C
Effective: April 1, 2021

Your Current Plan is Kaiser Permanente Silver HMO C		
Your Current Coverage and Cost:	Employee Only	$ 162.80
Your Current Coverage Renews at:	Employee Only	$ 164.78

Renewal Enrollment Worksheet (1 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles
Rating Zip: 90301 | Rating County: Los Angeles

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 *after* 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:
50 % of the Lowest Cost Employee Rate for HMO/EPO
0 % of the Dependent Rate for Same Plan as Above

Gold/Silver 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	HEALTH NET	HMO	SILVER HMO C	COMMUNITYCARE	$ 273.10	$ 136.55
2	KAISER PERMANENTE	HSA/HMO	SILVER HMO D	FULL	$ 278.68	$ 142.13
3	HEALTH NET	HMO	SILVER HMO A	WHOLECARE	$ 289.10	$ 152.55
4	UNITEDHEALTHCARE	HMO	SILVER HMO E	ALLIANCE	$ 291.09	$ 154.54
5	KAISER PERMANENTE	HMO	SILVER HMO E	FULL	$ 292.98	$ 156.43
6	KAISER PERMANENTE	HMO	SILVER HMO A	FULL	$ 297.97	$ 161.42
7	ANTHEM BLUE CROSS	HMO	SILVER HMO A	SELECT HMO	$ 299.94	$ 163.39
8	KAISER PERMANENTE	HMO	SILVER HMO C	FULL	$ 301.33	$ 164.78
9	KAISER PERMANENTE	HMO	SILVER HMO B	FULL	$ 303.48	$ 166.93
10	UNITEDHEALTHCARE	HMO	SILVER HMO B	ADVANTAGE	$ 307.99	$ 171.44
11	HEALTH NET	HMO	GOLD HMO D	SALUD HMO Y MAS	$ 316.59	$ 180.04
12	UNITEDHEALTHCARE	HMO	GOLD HMO B	ALLIANCE	$ 318.83	$ 182.28
13	HEALTH NET	HMO	GOLD HMO B	WHOLECARE	$ 325.06	$ 188.51
14	HEALTH NET	HMO	GOLD HMO C	WHOLECARE	$ 329.01	$ 192.46
15	KAISER PERMANENTE	HMO	GOLD HMO D	FULL	$ 335.18	$ 198.63
16	HEALTH NET	HMO	GOLD HMO A	WHOLECARE	$ 337.32	$ 200.77
17	UNITEDHEALTHCARE	HMO	GOLD HMO K	ADVANTAGE	$ 337.34	$ 200.79
18	UNITEDHEALTHCARE	HMO	GOLD HMO J	ALLIANCE	$ 338.18	$ 201.63
19	ANTHEM BLUE CROSS	HMO	SILVER HMO B	CALIFORNIACARE HMO	$ 347.02	$ 210.47
20	UNITEDHEALTHCARE	HMO	SILVER HMO A	SIGNATUREVALUE	$ 348.41	$ 211.86
21	HEALTH NET	HMO	GOLD HMO F	FULL	$ 354.13	$ 217.58
22	KAISER PERMANENTE	HMO	GOLD HMO B	FULL	$ 354.90	$ 218.35
23	UNITEDHEALTHCARE	HMO	GOLD HMO I	ADVANTAGE	$ 357.81	$ 221.26
24	UNITEDHEALTHCARE	HMO	GOLD HMO G	ALLIANCE	$ 367.22	$ 230.67
25	ANTHEM BLUE CROSS	HMO	GOLD HMO A	SELECT HMO	$ 371.89	$ 235.34
26	HEALTH NET	HMO	GOLD HMO E	FULL	$ 373.50	$ 236.95
27	KAISER PERMANENTE	HMO	GOLD HMO C	FULL	$ 375.95	$ 239.40
28	UNITEDHEALTHCARE	HMO	GOLD HMO A	SIGNATUREVALUE	$ 381.62	$ 245.07
29	UNITEDHEALTHCARE	HMO	GOLD HMO E	ADVANTAGE	$ 388.53	$ 251.98
30	UNITEDHEALTHCARE	HMO	GOLD HMO H	SIGNATUREVALUE	$ 404.77	$ 268.22
31	ANTHEM BLUE CROSS	HMO	GOLD HMO B	CALIFORNIACARE HMO	$ 430.30	$ 293.75
32	UNITEDHEALTHCARE	HMO	GOLD HMO F	SIGNATUREVALUE	$ 439.53	$ 302.98

Gold/Silver Plan Options & Rates

EPO Benefit Plans

	Health Plan	Type	Plan Name	Network	Monthly Premiums prior to Employer Contribution Employee Only	Your Cost per Pay Period Employee Only
33	OSCAR	EPO	SILVER EPO C	OSCAR EPO	$ 276.10	$ 139.55
34	OSCAR	HSA/EPO	SILVER EPO A	OSCAR EPO	$ 282.01	$ 145.46
35	OSCAR	EPO	SILVER EPO B	OSCAR EPO	$ 297.36	$ 160.81
36	OSCAR	EPO	GOLD EPO C	OSCAR EPO	$ 308.17	$ 171.62
37	OSCAR	EPO	GOLD EPO D	OSCAR EPO	$ 323.65	$ 187.10
38	OSCAR	EPO	SILVER EPO D	OSCAR EPO	$ 338.55	$ 202.00
39	OSCAR	EPO	GOLD EPO A	OSCAR EPO	$ 338.66	$ 202.11
40	OSCAR	EPO	GOLD EPO B	OSCAR EPO	$ 371.83	$ 235.28
41	ANTHEM BLUE CROSS	EPO	SILVER EPO A	PRUDENT BUYER	$ 415.00	$ 278.45
42	ANTHEM BLUE CROSS	HSA/EPO	SILVER EPO B	PRUDENT BUYER	$ 415.13	$ 278.58

WIRELESS WATCHDOGS L L C
Effective: April 1, 2021

Your Current Plan is Kaiser Permanente Silver HMO C		
Your Current Coverage and Cost:	Employee Only	$ 162.80
Your Current Coverage Renews at:	Employee Only	$ 164.78

Renewal Enrollment Worksheet (2 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles
Rating Zip: 90301 | Rating County: Los Angeles

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 *after* 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:
50 % of the Lowest Cost Employee Rate for HMO/EPO
0 % of the Dependent Rate for Same Plan as Above

Gold/Silver 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
43	ANTHEM BLUE CROSS	PPO	SILVER PPO B	SELECT PPO	$ 423.06	$ 286.51
44	ANTHEM BLUE CROSS	PPO	SILVER PPO C	PRUDENT BUYER	$ 423.06	$ 286.51
45	ANTHEM BLUE CROSS	PPO	SILVER PPO A	ADVANTAGE PPO	$ 426.46	$ 289.91
46	ANTHEM BLUE CROSS	PPO	GOLD PPO D	SELECT PPO	$ 479.72	$ 343.17
47	ANTHEM BLUE CROSS	PPO	GOLD PPO B	SELECT PPO	$ 487.10	$ 350.55
48	ANTHEM BLUE CROSS	PPO	GOLD PPO C	SELECT PPO	$ 507.06	$ 370.51
49	ANTHEM BLUE CROSS	PPO	GOLD PPO E	PRUDENT BUYER	$ 507.06	$ 370.51
50	ANTHEM BLUE CROSS	PPO	GOLD PPO A	ADVANTAGE PPO	$ 512.87	$ 376.32

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/documents/) for additional benefits.

Renewal Enrollment Worksheet (3 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

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	Health Net	UnitedHealthcare	Kaiser Permanente
Metal Tier & Plan Type	1 **SILVER HMO C**①	2 **SILVER HMO D**	3 **SILVER HMO A**①	4 **SILVER HMO E**	5 **SILVER HMO E**
Network Name	**CommunityCare**	**Full**	**WholeCare**	**Alliance**	**Full**
HSA Compatible	No	Yes	No	No	No
Deductible	$1,750 / $3,500 (applies to Max OOP)②	$2,500 / $2,800 / $5,000 (comb. Med/Rx ded; applies to Max OOP)⑤	None	$2,250 / $4,500 (applies to Max OOP)⑧	$2,600 / $5,200 (comb. Med/Rx ded; applies to Max OOP)⑪
DR. OFFICE VISITS	$50 Copay (ded waived)	80%	$50 Copay	$50 Copay (ded waived)	$55 Copay (ded waived)
Lab and X-Ray	$50 Copay	80%	$50 Copay	$45 Copay (ded waived)	$75 Copay
Specialist Visit	$70 Copay (ded waived)	80%	$70 Copay	$90 Copay (ded waived)	$80 Copay (ded waived)
HOSPITAL SERVICES	60%	80%	50%	60%	55%
Emergency Room	60%	80%	50%	60%	55%
Urgent Care	$70 Copay (ded waived)	80%	$70 Copay	$100 Copay (ded waived)	$55 Copay (ded waived)
Out-Patient Surgery	60%	80%	50%	60%	55%
RX BENEFITS - Generic	$15 Copay (ded waived)③	80% (up to $250 per prescription; comb. Med/Rx ded)⑦	$20 Copay (ded waived)③	$15 Copay (ded waived)	$20 Copay (ded waived)
RX BENEFITS - Formulary Brand	$250 / $500 Ded - 60% (up to $250 per prescription)④	80% (up to $250 per prescription; comb. Med/Rx ded)⑦	$750 / $1,500 Ded - 50% (up to $250 per prescription)④	$300 / $600 Ded - $50 Copay⑩	$75 Copay (comb. Med/Rx ded)
Out-of-Pocket Max-Ind/Fam	$7,800 / $15,600	$6,850 / $13,700⑥	$7,950 / $15,900	$8,550 / $17,100⑨	$8,200 / $16,400⑥

Health Plan	Kaiser Permanente	Anthem Blue Cross	Kaiser Permanente	Kaiser Permanente	UnitedHealthcare
Metal Tier & Plan Type	6 **SILVER HMO A**	7 **SILVER HMO A**①	8 **SILVER HMO C**	9 **SILVER HMO B**	10 **SILVER HMO B**
Network Name	**Full**	**Select HMO**	**Full**	**Full**	**Advantage**
HSA Compatible	No	No	No	No	No
Deductible	$2,100 / $4,200 (applies to Max OOP)⑪	$2,200 / $4,400 (comb. Med/Ped dent; applies to Max OOP)⑫	$2,250 / $4,500 (applies to Max OOP)⑪	$1,650 / $3,300 (applies to Max OOP)⑪	$2,250 / $4,500 (applies to Max OOP)⑧
DR. OFFICE VISITS	$55 Copay (ded waived)	$60 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)	$50 Copay (ded waived)
Lab and X-Ray	$75 Copay (ded waived)	$20 Copay (ded waived)⑭	$90 Copay (ded waived)	$75 Copay (ded waived)	$45 Copay (ded waived)
Specialist Visit	$80 Copay (ded waived)	$110 Copay (ded waived)	$90 Copay (ded waived)	$80 Copay (ded waived)	$90 Copay (ded waived)
HOSPITAL SERVICES	55%	55%	70%	60%	60%
Emergency Room	55%	$350 Copay (waived if admitted) - 55%	70%	60%	60%
Urgent Care	$55 Copay (ded waived)	$60 Copay (ded waived)	$55 Copay (ded waived)	$55 Copay (ded waived)	$100 Copay (ded waived)
Out-Patient Surgery	55%	55%	70%	60%	60%
RX BENEFITS - Generic	$20 Copay (ded waived)	$20 Copay / $25 Copay (ded waived)⑮	$17 Copay (ded waived)	$20 Copay (ded waived)	$15 Copay (ded waived)
RX BENEFITS - Formulary Brand	$500 / $1,000 Ded - $75 Copay	$300 / $600 Ded - $85 Copay / $110 Copay⑮	$300 / $600 Ded - $80 Copay	$350/$700 Ded - $75 Copay	$300 / $600 Ded - $50 Copay⑩
Out-of-Pocket Max-Ind/Fam	$8,200 / $16,400⑥	$8,400 / $16,800⑬	$8,200 / $16,400⑥	$8,200 / $16,400⑥	$8,550 / $17,100⑨

Health Plan	Health Net	UnitedHealthcare	Health Net	Health Net	Kaiser Permanente
Metal Tier & Plan Type	11 **GOLD HMO D**①	12 **GOLD HMO B**	13 **GOLD HMO B**①	14 **GOLD HMO C**①	15 **GOLD HMO D**
Network Name	**Salud HMO y Mas**	**Alliance**	**WholeCare**	**WholeCare**	**Full**
HSA Compatible	No	No	No	No	No
Deductible	None	$1,250 / $2,500 (applies to Max OOP)⑧	None	None	$1,000 / $2,000 (applies to Max OOP)⑪
DR. OFFICE VISITS	$35 Copay	$30 Copay (ded waived)	$45 Copay	$35 Copay	$40 Copay (ded waived)
Lab and X-Ray	$50 Copay	$30 Copay (ded waived)	$50 Copay	$50 Copay	$60 Copay (ded waived)
Specialist Visit	$55 Copay	$70 Copay (ded waived)	$65 Copay	$55 Copay	$60 Copay (ded waived)
HOSPITAL SERVICES	$750 Copay per day - 3 days max	70%	$1,000 Copay	$750 Copay per day - 3 days max	$600 Copay per day - 5 days max
Emergency Room	$300 Copay (waived if admitted)	70%	$300 Copay (waived if admitted)	$300 Copay (waived if admitted)	$350 Copay (ded waived; waived if admitted)
Urgent Care	$55 Copay	$75 Copay (ded waived)	$65 Copay	$55 Copay	$40 Copay (ded waived)
Out-Patient Surgery	$1,200 Copay	70%	60%	$1,200 Copay	$350 Copay per procedure (ded waived)
RX BENEFITS - Generic	$15 Copay③	$10 Copay (ded waived)	$15 Copay③	$15 Copay③	$20 Copay (ded waived)
RX BENEFITS - Formulary Brand	$50 Copay③	$250 / $500 Ded - $40 Copay⑩	$50 Copay⑰	$50 Copay③	$250 / $500 Ded - $50 Copay
Out-of-Pocket Max-Ind/Fam	$6,500 / $13,000⑯	$7,800 / $15,600⑨	$7,000 / $14,000	$6,500 / $13,000	$7,800 / $15,600⑥

Pediatric Dental and Vision benefits are included in all health plans.

Renewal Enrollment Worksheet (4 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

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	UnitedHealthcare	UnitedHealthcare	Anthem Blue Cross	UnitedHealthcare
Metal Tier & Plan Type	16 **GOLD HMO A**①	17 **GOLD HMO K**	18 **GOLD HMO J**	19 **SILVER HMO B**	20 **SILVER HMO A**
Network Name	**WholeCare**	**Advantage**	**Alliance**	**CaliforniaCare HMO**	**SignatureValue**
HSA Compatible	No	No	No	No	No
Deductible	None	$1,250 / $2,500 (applies to Max OOP)⑧	$500 / $1,000 (applies to Max OOP)⑧	$2,200 / $4,400 (comb. Med/Ped dent; applies to Max OOP)⑫	$2,250 / $4,500 (applies to Max OOP)⑧
DR. OFFICE VISITS	$30 Copay	$30 Copay (ded waived)	$30 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
Lab and X-Ray	$50 Copay	$30 Copay (ded waived)	$30 Copay (ded waived)	$20 Copay (ded waived)⑭	$45 Copay (ded waived)
Specialist Visit	$50 Copay	$70 Copay (ded waived)	$70 Copay (ded waived)	$110 Copay (ded waived)	$90 Copay (ded waived)
HOSPITAL SERVICES	$750 Copay per day - 3 days max	70%	80%	55%	60%
Emergency Room	$300 Copay (waived if admitted)	70%	$500 Copay (waived if admitted)	$350 Copay (waived if admitted) - 55%	60%
Urgent Care	$50 Copay	$75 Copay (ded waived)	$75 Copay (ded waived)	$60 Copay (ded waived)	$100 Copay (ded waived)
Out-Patient Surgery	60%	70%	80%	55%	60%
RX BENEFITS - Generic	$15 Copay③	$10 Copay (ded waived)	$10 Copay (ded waived)	$20 Copay / $25 Copay (ded waived)⑮	$15 Copay (ded waived)
RX BENEFITS - Formulary Brand	$50 Copay⑰	$250 / $500 Ded - $40 Copay⑩	$250 / $500 Ded - $40 Copay⑩	$300 / $600 Ded - $85 Copay / $110 Copay⑮	$300 / $600 Ded - $50 Copay⑩
Out-of-Pocket Max-Ind/Fam	$7,000 / $14,000	$7,800 / $15,600⑨	$7,500 / $15,000⑨	$8,400 / $16,800⑬	$8,550 / $17,100⑨

Health Plan	Health Net	Kaiser Permanente	UnitedHealthcare	UnitedHealthcare	Anthem Blue Cross
Metal Tier & Plan Type	21 **GOLD HMO F**①	22 **GOLD HMO B**	23 **GOLD HMO I**	24 **GOLD HMO G**	25 **GOLD HMO A**①
Network Name	**Full**	**Full**	**Advantage**	**Alliance**	**Select HMO**
HSA Compatible	No	No	No	No	No
Deductible	None	$250 / $500 (applies to Max OOP)⑪	$500 / $1,000 (applies to Max OOP)⑧	None	None
DR. OFFICE VISITS	$45 Copay	$35 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay	$30 Copay
Lab and X-Ray	$50 Copay	$55 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay	$15 Copay⑭
Specialist Visit	$65 Copay	$55 Copay (ded waived)	$70 Copay (ded waived)	$70 Copay	$55 Copay
HOSPITAL SERVICES	$1,000 Copay	$600 Copay per day, 5 days max	80%	$800 Copay per day - 5 days max per admit	$550 Copay per day - 4 days max per admit
Emergency Room	$300 Copay (waived if admitted)	$250 Copay (waived if admitted)	$500 Copay (waived if admitted)	$500 Copay (waived if admitted)	$300 Copay (waived if admitted)
Urgent Care	$65 Copay	$35 Copay (ded waived)	$75 Copay (ded waived)	$75 Copay	$30 Copay
Out-Patient Surgery	60%	$335 Copay per procedure	80%	$500 Copay	$450 Copay
RX BENEFITS - Generic	$15 Copay③	$15 Copay (overall ded waived)	$10 Copay (ded waived)	$10 Copay (ded waived)	$15 Copay / $25 Copay⑮
RX BENEFITS - Formulary Brand	$50 Copay③	$40 Copay (overall ded waived)	$250 / $500 Ded - $40 Copay⑩	$100 / $200 Ded - $40 Copay⑩	$40 Copay / $60 Copay⑮
Out-of-Pocket Max-Ind/Fam	$7,000 / $14,000	$7,800 / $15,600⑥	$7,500 / $15,000⑨	$7,000 / $14,000⑨	$6,000 / $12,000⑬

Health Plan	Health Net	Kaiser Permanente	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Metal Tier & Plan Type	26 **GOLD HMO E**①	27 **GOLD HMO C**	28 **GOLD HMO A**	29 **GOLD HMO E**	30 **GOLD HMO H**
Network Name	**Full**	**Full**	**SignatureValue**	**Advantage**	**SignatureValue**
HSA Compatible	No	No	No	No	No
Deductible	None	None	$1,250 / $2,500 (applies to Max OOP)⑧	None	$500 / $1,000 (applies to Max OOP)⑧
DR. OFFICE VISITS	$35 Copay	$30 Copay	$30 Copay (ded waived)	$30 Copay	$30 Copay (ded waived)
Lab and X-Ray	$50 Copay	$40 Copay	$30 Copay (ded waived)	$30 Copay	$30 Copay (ded waived)
Specialist Visit	$55 Copay	$35 Copay	$70 Copay (ded waived)	$70 Copay	$70 Copay (ded waived)
HOSPITAL SERVICES	$750 Copay per day - 3 days max	$600 Copay per day - 5 days max	70%	$800 Copay per day - 5 days max per admit	80%
Emergency Room	$300 Copay (waived if admitted)	$250 Copay (waived if admitted)	70%	$500 Copay (waived if admitted)	$500 Copay (waived if admitted)
Urgent Care	$55 Copay	$30 Copay	$75 Copay (ded waived)	$75 Copay	$75 Copay (ded waived)
Out-Patient Surgery	$1,200 Copay	$320 Copay per procedure	70%	$500 Copay	80%
RX BENEFITS - Generic	$15 Copay③	$15 Copay	$10 Copay (ded waived)	$10 Copay (ded waived)	$10 Copay (ded waived)
RX BENEFITS - Formulary Brand	$50 Copay③	$40 Copay	$250 / $500 Ded - $40 Copay⑩	$100 / $200 Ded - $40 Copay⑩	$250 / $500 Ded - $40 Copay⑩
Out-of-Pocket Max-Ind/Fam	$6,500 / $13,000	$7,000 / $14,000⑥	$7,800 / $15,600⑨	$7,000 / $14,000⑨	$7,500 / $15,000⑨

Pediatric Dental and Vision benefits are included in all health plans.

Renewal Enrollment Worksheet (5 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

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		UnitedHealthcare
Metal Tier & Plan Type	31	**GOLD HMO B**	32	**GOLD HMO F**
Network Name		**CaliforniaCare HMO**		**SignatureValue**
HSA Compatible		No		No
Deductible		None		None
DR. OFFICE VISITS		$30 Copay		$30 Copay
Lab and X-Ray		$15 Copay⑭		$30 Copay
Specialist Visit		$55 Copay		$70 Copay
HOSPITAL SERVICES		$550 Copay per day - 4 days max per admit		$800 Copay per day - 5 days max per admit
Emergency Room		$300 Copay (waived if admitted)		$500 Copay (waived if admitted)
Urgent Care		$30 Copay		$75 Copay
Out-Patient Surgery		$450 Copay		$500 Copay
RX BENEFITS - Generic		$15 Copay / $25 Copay⑮		$10 Copay (ded waived)
RX BENEFITS - Formulary Brand		$40 Copay / $60 Copay⑮		$100 / $200 Ded - $40 Copay⑩
Out-of-Pocket Max-Ind/Fam		$6,000 / $12,000⑬		$7,000 / $14,000⑨

Renewal Enrollment Worksheet (6 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

EPO Summary of Benefits

Under an EPO plan, you do not choose a Primary Care Physician (PCP). You can receive care from any of the in-network doctors and self refer to in-network specialists.

Health Plan		Oscar		Oscar		Oscar		Oscar		Oscar
Metal Tier & Plan Type	33	**SILVER EPO C**	34	**SILVER EPO A**③	35	**SILVER EPO B**③	36	**GOLD EPO C**③	37	**GOLD EPO D**
Network Name		**Oscar EPO**		**Oscar EPO**		**Oscar EPO**		**Oscar EPO**		**Oscar EPO**
HSA Compatible		No		Yes		No		No		No
Deductible		$1,500 / $3,000 (comb. Med/Rx/Ped dent; applies to Max OOP)①		$2,500 / $2,800 / $5,000 (comb. Med/Rx/Ped dent; applies to Max OOP)④		$2,250 / $4,500 (comb. Med/Ped dent; applies to Max OOP)①		$2,000 / $4,000 (comb. Med/Rx/Ped dent; applies to Max OOP)①		$1,000 / $2,000 (comb. Med/Rx/Ped dent; applies to Max OOP)①
DR. OFFICE VISITS		$50 Copay (ded waived)		80%		$55 Copay (ded waived)		$30 Copay (ded waived)		$25 Copay (ded waived)
Lab and X-Ray		$75 Copay (ded waived)②		80%②		$90 Copay (ded waived)②		$55 Copay (ded waived)②		$55 Copay (ded waived)②
Specialist Visit		$75 Copay (ded waived)		80%		$90 Copay (ded waived)		$60 Copay (ded waived)		$60 Copay (ded waived)
HOSPITAL SERVICES		50%		80%		70%		80%		80%
Emergency Room		$750 Copay (ded waived; waived if admitted)		80%		70%		$600 Copay (ded waived; waived if admitted)		$600 Copay (ded waived; waived if admitted)
Urgent Care		$75 Copay (ded waived)		80%		$55 Copay (ded waived)		$50 Copay (ded waived)		$50 Copay (ded waived)
Out-Patient Surgery		50%		80%		70%		80%		80%
RX BENEFITS - Generic		$25 Copay (ded waived)		80% (up to $250 per prescription; comb. Med/Rx/Ped dent)⑤		$17 Copay (ded waived)		$10 Copay (ded waived)		$15 Copay (ded waived)
RX BENEFITS - Formulary Brand		$55 Copay (ded waived)		80% (up to $250 per prescription; comb. Med/Rx/Ped dent)⑤		$300 / $600 Ded - $80 Copay		$50 Copay (ded waived)		$50 Copay (ded waived)
Out-of-Pocket Max-Ind/Fam		$8,300 / $16,600		$6,850 / $13,700		$8,200 / $16,400		$8,000 / $16,000		$8,550 / $17,100

Health Plan		Oscar		Oscar		Oscar		Anthem Blue Cross		Anthem Blue Cross
Metal Tier & Plan Type	38	**SILVER EPO D**③	39	**GOLD EPO A**③	40	**GOLD EPO B**③	41	**SILVER EPO A**③	42	**SILVER EPO B**③
Network Name		**Oscar EPO**		**Oscar EPO**		**Oscar EPO**		**Prudent Buyer - Small Group**		**Prudent Buyer - Small Group**
HSA Compatible		No		No		No		No		Yes
Deductible		None		None		$250 / $500 (comb. Med/Ped dent; applies to Max OOP)①		$2,200 / $4,400 (comb. Med/Ped dent; applies to Max OOP)⑥		$2,000 / $2,800 / $4,000 (comb. Med/Rx/Ped dent; applies to Max OOP)⑨
DR. OFFICE VISITS		$50 Copay		$30 Copay		$35 Copay (ded waived)		$50 Copay (ded waived)		70%
Lab and X-Ray		$80 Copay②		$60 Copay②		$55 Copay (ded waived)②		$20 Copay (ded waived)		70%
Specialist Visit		$80 Copay		$60 Copay		$55 Copay (ded waived)		$100 Copay (ded waived)		70%
HOSPITAL SERVICES		$1,500 Copay per admit		70%		$600 Copay per day - 5 days max per admit		60%		70%
Emergency Room		$650 Copay (waived if admitted)		$350 Copay (waived if admitted)		$250 Copay (waived if admitted)		$300 Copay (waived if admitted) - 60%		70%
Urgent Care		$80 Copay		$50 Copay		$35 Copay (ded waived)		$100 Copay (ded waived)		70%
Out-Patient Surgery		$250 Copay		70%		80%		$200 Copay per admit - 60%		$200 Copay per admit - 70%
RX BENEFITS - Generic		$20 Copay		$15 Copay		$15 Copay (overall ded waived)		$20 Copay / $25 Copay (ded waived)⑧		70% / 60% (up to $250 per prescription; comb. Med/Rx/Ped dent)⑩
RX BENEFITS - Formulary Brand		$50 Copay		$50 Copay		$40 Copay (overall ded waived)		$300 / $600 Ded - $60 Copay / $95 Copay⑧		70% / 60% (up to $250 per prescription; comb. Med/Rx/Ped dent)⑩
Out-of-Pocket Max-Ind/Fam		$8,550 / $17,100		$6,500 / $13,000		$7,800 / $15,600		$8,400 / $16,800⑦		$6,750 / $13,500⑦

Pediatric Dental and Vision benefits are included in all health plans.

Renewal Enrollment Worksheet (7 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

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	43 **SILVER PPO B**①	44 **SILVER PPO C**①	45 **SILVER PPO A**①	46 **GOLD PPO D**①	47 **GOLD PPO B**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Advantage PPO**	**Select PPO**	**Select PPO**
HSA Compatible	No	No	No	No	No
Deductible	$1,700 / $3,400 (comb. Med/Ped dent; applies to Max OOP)②	$1,700 / $3,400 (comb. Med/Ped dent; applies to Max OOP)②	$1,600 / $3,200 (comb. Med/Ped dent; applies to Max OOP)②	$1,200 / $2,400 (comb. Med/Ped dent; applies to Max OOP)②	$1,000 / $3,000 (comb. Med/Ped dent; applies to Max OOP)②
DR. OFFICE VISITS	$50 Copay (ded waived)	$50 Copay (ded waived)	$45 Copay (ded waived)	$30 Copay (ded waived)	$25 Copay (ded waived)
Lab and X-Ray	$20 Copay (ded waived)	$20 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$95 Copay (ded waived)	$95 Copay (ded waived)	$90 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
HOSPITAL SERVICES	60%	60%	Tier 1: 60% Tier 2: $500 Copay per admit - 60%	75%	75%
Emergency Room	$300 Copay (waived if admitted) - 60%	$300 Copay (waived if admitted) - 60%	$350 Copay (waived if admitted) - 60%	$250 Copay (waived if admitted) - 75%	$250 Copay (waived if admitted) - 75%
Urgent Care	$95 Copay (ded waived)	$95 Copay (ded waived)	$90 Copay (ded waived)	$60 Copay (ded waived)	$50 Copay (ded waived)
Out-Patient Surgery	$200 Copay per admit - 60%	$200 Copay per admit - 60%	Tier 1: 60% Tier 2: $250 Copay per admit - 60%	$200 Copay per admit - 75%	$200 Copay per admit - 75%
RX BENEFITS - Generic	$20 Copay / $25 Copay (ded waived)④	$20 Copay / $25 Copay (ded waived)④	$20 Copay / $25 Copay (ded waived)④	$15 Copay / $25 Copay (ded waived)④	$15 Copay / $25 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$300 / $600 Ded - $60 Copay / $95 Copay④	$300 / $600 Ded - $60 Copay / $95 Copay④	$300 / $600 Ded - $60 Copay / $95 Copay④	$250 / $500 Ded - $45 Copay / $65 Copay④	$250 / $500 Ded - $45 Copay / $65 Copay④
Out-of-Pocket Max-Ind/Fam	$8,150 / $16,300③	$8,150 / $16,300③	$8,500 / $17,000③	$7,000 / $14,000③	$6,700 / $13,400③
OUT-OF-NETWORK					
Network Name	N/A	N/A	N/A	N/A	N/A
HSA Compatible	No	No	No	No	No
Deductible	$3,400 / $6,800 (comb. Med/Ped dent; applies to Max OOP)②	$3,400 / $6,800 (comb. Med/Ped dent; applies to Max OOP)②	$3,200 / $6,400 (comb. Med/Ped dent; applies to Max OOP)②	$2,400 / $4,800 (comb. Med/Ped dent; applies to Max OOP)②	$2,000 / $4,000 (comb. Med/Ped dent; 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%	$300 Copay (waived if admitted) - 60%	$350 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	$16,300 / $32,600③	$16,300 / $32,600③	$17,000 / $34,000③	$14,000 / $28,000③	$13,400 / $26,800③

Pediatric Dental and Vision benefits are included in all health plans.

Renewal Enrollment Worksheet (8 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

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
IN NETWORK			
Metal Tier & Plan Type	48 **GOLD PPO C**①	49 **GOLD PPO E**①	50 **GOLD PPO A**①
Network Name	**Select PPO**	**Prudent Buyer - Small Group**	**Advantage PPO**
HSA Compatible	No	No	No
Deductible	$500 / $1,500 (comb. Med/Ped dent; applies to Max OOP)②	$500 / $1,500 (comb. Med/Ped dent; applies to Max OOP)②	$500 / $1,500 (comb. Med/Ped dent; applies to Max OOP)②
DR. OFFICE VISITS	$30 Copay (ded waived)	$30 Copay (ded waived)	$30 Copay (ded waived)
Lab and X-Ray	$15 Copay (ded waived)	$15 Copay (ded waived)	$15 Copay (ded waived)
Specialist Visit	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)
HOSPITAL SERVICES	80%	80%	Tier 1: 80% Tier 2: $500 Copay per admit - 80%
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%
Urgent Care	$60 Copay (ded waived)	$60 Copay (ded waived)	$60 Copay (ded waived)
Out-Patient Surgery	$200 Copay per admit - 80%	$200 Copay per admit - 80%	Tier 1: 80% Tier 2: $250 Copay per admit - 80%
RX BENEFITS - Generic	$15 Copay / $25 Copay (ded waived)④	$15 Copay / $25 Copay (ded waived)④	$15 Copay / $25 Copay (ded waived)④
RX BENEFITS - Formulary Brand	$200 / $400 Ded - $45 Copay / $65 Copay④	$200 / $400 Ded - $45 Copay / $65 Copay④	$200 / $400 Ded - $45 Copay / $65 Copay④
Out-of-Pocket Max-Ind/Fam	$6,400 / $12,800③	$6,400 / $12,800③	$6,500 / $13,000③
OUT-OF-NETWORK			
Network Name	N/A	N/A	N/A
HSA Compatible	No	No	No
Deductible	$2,000 / $4,000 (comb. Med/Ped dent; applies to Max OOP)②	$2,000 / $4,000 (comb. Med/Ped dent; applies to Max OOP)②	$2,000 / $4,000 (comb. Med/Ped dent; applies to Max OOP)②
DR. OFFICE VISITS	50%	50%	50%
Lab and X-Ray	50%	50%	50%
Specialist Visit	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
Emergency Room	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%	$250 Copay (waived if admitted) - 80%
Urgent Care	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
RX BENEFITS - Generic	Not Covered	Not Covered	Not Covered
RX BENEFITS - Formulary Brand	Not Covered	Not Covered	Not Covered
Out-of-Pocket Max-Ind/Fam	$12,800 / $25,600③	$12,800 / $25,600③	$13,000 / $26,000③

Renewal Enrollment Worksheet (9 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

Notes:

HMO 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.

② All services are subject to the deductible unless otherwise stated.

③ 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.

④ 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. Maximum member responsibility.

⑤ All services are subject to the deductible unless otherwise stated. $2,500 Self only enrollment, $2,800 for any one member within a Family enrollment, $5,000 for an entire Family. Does not apply to preventive care.

⑥ Under a family contract, an insured can satisfy their individual out-of-pocket maximum; however, an insured may not contribute an amount greater than the individual maximum copayment limit toward the family maximum.

⑦ Maximum member responsibility.

⑧ All services are subject to the deductible unless otherwise stated. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.

⑨ When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.

⑩ For Specialty drugs, please see plan specific EOC.

⑪ 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.

⑫ 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.

⑬ 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.

⑭ Amount listed is for office visits only, please see plan specific EOC for other settings/services and devices cost shares.

⑮ The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2a typically lower cost preferred brand and non-preferred generics; tier 2b typically preferred brand and non-preferred generics; tier 3a typically lower cost non-preferred brand drugs; tier 3b typically non-preferred brand drugs; tier 4a typically lower cost specialty (brand and generic) drugs; tier 4b typically specialty (brand and generic) drugs.

⑯ Certain services available in Mexico, have a separate out-of-pocket maximum, but out-of-pocket costs for services received in Mexico and California apply toward satisfaction of both out-of pocket maximums.

⑰ The four prescription drug tiers are Tier 1: Generic formulary; Tier 2: Brand formulary; Tier 3: Brand non-formulary; Tier 4: Specialty. The brand-name prescription drug deductible (per member, per calendar year) must be paid before Health Net begins to pay for brand-name prescription drugs. See plan specific EOC for information regarding preventive drugs and women's contraceptives.

EPO Plans

① All services are subject to the deductible unless otherwise stated.

② Prior-Authorization may be required.

③ 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.

④ All services are subject to the deductible unless otherwise stated. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.

⑤ Maximum member responsibility.

⑥ 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.

⑦ 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.

⑧ The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2a typically lower cost preferred brand and non-preferred generics; tier 2b typically preferred brand and non-preferred generics; tier 3a typically lower cost non-preferred brand drugs; tier 3b typically non-preferred brand drugs; tier 4a typically lower cost specialty (brand and generic) drugs; tier 4b typically specialty (brand and generic) drugs.

Renewal Enrollment Worksheet (10 of 10)

Regina Mitchell | Female | Age: 27
Zip: 90044 | County: Los Angeles

Notes (cont.)

⑨ All services are subject to the deductible unless otherwise stated. Deductible applies depending on who is covered under the plan at the time service is rendered - Subscriber only: $2,000 individual deductible; or Subscriber and Family coverage: $2,800 individual and $4,000 family deductible. For family deductible, for any given member, cost share applies either after he/she meets the per member deductible, or after the entire family deductible is met. The per family deductible can be met by any combination of amounts from any member, however no one member may contribute any more than his/her per member deductible toward the family deductible.

⑩ The four prescription drug tiers are: tier 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2a typically lower cost preferred brand and non-preferred generics; tier 2b typically preferred brand and non-preferred generics; tier 3a typically lower cost non-preferred brand drugs; tier 3b typically non-preferred brand drugs; tier 4a typically lower cost specialty (brand and generic) drugs; tier 4b typically specialty (brand and generic) drugs. Maximum member responsibility.

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 1a typically lower cost generic drugs; tier 1b typically generic drugs; tier 2a typically lower cost preferred brand and non-preferred generics; tier 2b typically preferred brand and non-preferred generics; tier 3a typically lower cost non-preferred brand drugs; tier 3b typically non-preferred brand drugs; tier 4a typically lower cost specialty (brand and generic) drugs; tier 4b typically specialty (brand and generic) drugs.

⑤ Amount listed is maximum paid by Anthem.