KHEO
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EMPLOYEE BENEFITS 2017 HEALTH PLAN COMPARISON CHART

MEDICAL

Plan Benefits	Anthem Blue Cross HMO			Anthem Blue Cross PPO			
	Premier HMO 10	Premier HMO 20	Classic HMO 35	Premier PPO 250		Classic PPO 500	
	In-Network			In-Network	Out-of-Network	In-Network	Out-of-Network
	Member Responsibility			Member Responsibility			
Plan Year Deductible (Individual / Family)	None	None	None	$250 / $750	$250 / $750	$500 / $1,500	$1,500 / $4,500
Annual Out-of-Pocket Maximum (Individual / Family)	$1,500 / $3,000	$1,500 / $3,000	$2,500 / $5,000	$2,500 / $5,000	$7,500 / $15,000	$3,500 / $7,000	$10,500 / $21,000
• Inpatient Hospitalization	No charge	$200/admit	$750/admit	10%	30% (max $1,000/day)	20%	40% (max $1,000/day)
• Outpatient Surgery & Other Services	No charge	$100/procedure	$375/procedure	10%	30% (max $350/admit)	20%	40% (max $350/admit)
• Office Visit (Primary Care / Specialist)	$10	$20	$35 / $45	$15 †	30%	$20 †	40%
• Urgent Care	$10	$20	$35	$15 †	30%	$20 †	40%
• Emergency Room Services*	$100	$100	$100	$100, then 10%	$100, then 10%	$150, then 20%	$150, then 20%
• Ambulance	$100/trip	$100/trip	$100/trip	10%	10%	20%	20%
• Preventive Care	No charge	No charge	No charge	No charge †	30%	No charge †	40%
• Physical, Speech, Occupational Therapy	$10	$20	$35	10%	30%	20%	40%
• Chiropractic Therapy, Acupuncture	$10	$20	$35	$15 †	30%	$20 †	40%
• Pre-Natal Care	$10	$20	$35	$15 †	30%	$20 †	40%
• X-Ray and Lab	No charge	No charge	No charge	10%	30%	20%	40%
• Advanced Imaging (MRI, PET, CAT)	$100/test	$100/test	$100/test	10%	30% (max $800/test)	20%	40% (max $800/test)
• Skilled Nursing Facility (100 days)	No charge	No charge	No charge	10%	30%	20%	40%
• Home Health Care (100 visits)	$10	$20	$35	10%	30%	20%	40%
• Hospice Care	No charge	No charge	No charge	No charge †	30%	No charge †	40%
Prescription Drugs		**ESSENTIAL FORMULARY ‡**				**ESSENTIAL FORMULARY ‡**	
• Rx Deductible (Individual / Familiy)	None	None	$150 / $450	None	None	None	None
Retail (30-day supply)							
• Generic / Tier 1	$5	$10	$15 †	$5	50%	$10	50%
• Formulary Brand / Tier 2	$15	$25	$40	$15	50%	$25	50%
• Non-Formulary Brand / Tier 3	$30	$40	$55	$30	50%	$40	50%
• Specialty / Tier 4	20% up to $150	20% up to $150	30% up to $250	20% up to $150	50%	20% up to $150	50%
Mail Order (90-day supply)							
• Generic / Tier 1	$5	$10	$37.50 †	$5	N/A	$10	N/A
• Formulary Brand / Tier 2	$30	$50	$120	$30	N/A	$50	N/A
• Non-Formulary Brand / Tier 3	$60	$80	$165	$60	N/A	$80	N/A
• Specialty / Tier 4	20% up to $300	20% up to $300	30% up to $250	20% up to $300	N/A	20% up to $300	N/A

* Emergency Room copay waived if admitted
† Deductible waived
‡ The Essential Formulary offers a variety of brand & generic medication choices. It provides savings by excluding drugs that have lower-cost formulary or over-the-counter (OTC) alternatives, and brands with a generic equivalent. Your doctor can request an exception review if a drug is prescribed that is not covered by the Essential Formulary.

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MEDICAL

Plan Benefits	Anthem Blue Cross HSA					
	Lumenos HSA 2600		Lumenos HSA 1300/2600		Lumenos HSA 3000	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Member Responsibility					
Plan Year Deductible (Individual / Family)	$2,600 / $5,200	$7,800 / $16,200	$1,300 single participant ** / $2,600 per family member / $3,000 family max	$3,900 single participant ** / $3,900 per family member / $7,800 family max	$3,000 / $6,000	
Annual Out-of-Pocket Maximum (Individual / Family)	$5,000 / $10,000	$15,000 / $30,000	$3,000 / $6,000	$9,000 / $18,000	$5,000 / $10,000	$10,000 / $20,000
• Inpatient Hospitalization	No charge	30% (max $1,000/day)	10%	30% (max $1,000/day)	20%	40% (max $1,000/day)
• Outpatient Surgery & Other Services	No charge	30% (max $350/day)	10%	30% (max $350/day)	20%	40% (max $350/day)
• Office Visit (Primary Care / Specialist)	No charge	30%	10%	30%	20%	40%
• Urgent Care	No charge	30%	10%	30%	20%	40%
• Emergency Room Services*	No charge	No charge	10%	10%	20%	20%
• Ambulance	No charge	No charge	10%	10%	20%	20%
• Preventive Care	No charge †	30%	No charge †	30%	No charge †	40%
• Physical, Speech, Occupational Therapy	No charge	30%	10%	30%	20%	40%
• Chiropractic Therapy, Acupuncture	No charge	30%	10%	30%	20%	40%
• Pre-Natal Care	No charge	30%	10%	30%	20%	40%
• X-Ray and Lab	No charge	30%	10%	30%	20%	40%
• Advanced Imaging (MRI, PET, CAT)	No charge	30% (max $800/test)	10%	30% (max $800/test)	20%	40% (max $800/test)
• Skilled Nursing Facility (100 days)	No charge	30%	10%	30%	20%	40%
• Home Health Care (100 visits)	No charge	30%	10%	30%	20%	40%
• Hospice Care	No charge	30%	10%	30%	20%	40%
Prescription Drugs	**COPAYS APPLY AFTER DEDUCTIBLE**					
Retail (30-day supply)	**ESSENTIAL FORMULARY ‡**					
• Generic / Tier 1	$5-$15	30%	$5-$15	30%	$10	40%
• Formulary Brand / Tier 2	$40	30%	$40	30%	$30	40%
• Non-Formulary Brand / Tier 3	$60	30%	$60	30%	$50	40%
• Specialty / Tier 4	30% up to $250	30%	30% up to $250	30%	30% up to $150	40%
Mail Order (90-day supply)						
• Generic / Tier 1	$12.50-$37.50	N/A	$12.50-$37.50	N/A	$10	N/A
• Formulary Brand / Tier 2	$120	N/A	$120	N/A	$60	N/A
• Non-Formulary Brand / Tier 3	$180	N/A	$180	N/A	$100	N/A
• Specialty / Tier 4	30% up to $250	N/A	30% up to $250	N/A	30% up to $300	N/A

HSA contribution limit for 2017: $3,400 individual / $6,750 family

* Emergency Room copay waived if admitted

** HSA 1300/2600: Single Participant Deductible applies to members enrolled in single only coverage (defined as individual coverage without dependents.) No one member enrolled in family coverage will pay more than the per family member deductible; the family collectively will pay no more than the family maximum deductible.

† Deductible waived

‡ The Essential Formulary offers a variety of brand & generic medication choices. It provides savings by excluding drugs that have lower-cost formulary or over-the-counter (OTC) alternatives, and brands with a generic equivalent. Your doctor can request an exception review if a drug is prescribed that is not covered by the Essential Formulary.

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DENTAL

Plan Benefits	Anthem Dental Net HMO	Anthem Blue Cross Dental Complete PPO	
		In-Network	Out-of-Network*
		Member Responsibility	
Calendar Year Deductible	None	$50 per Individual /	$50 per Individual /
		$150 per Family	$150 per Family
Annual Maximum Benefit	N/A	Plan Pays up to $1,500	Plan Pays up to $1,500
Diagnostic & Preventive Services			
• Oral Exams, Cleanings, X-Rays, Fluoride	$0 copay	No charge (deductible waived)	No charge* (deductible waived)
Basic Services			
Basic Services	$0 copay	20%	20%
• Fillings (resin based composite)	$0 – $85 copay	20%	20%
• Endodontics (root canals)	$0 – $240 copay	20%	20%
• Oral Surgery"	$0 – $85 copay	20%	20%
• Periodontics (gum treatment)	$22 – $180 copay	20%	20%
Major Services			
• Crowns, Inlays, Onlays	$0 – $225 copay	50%	50%
• Prosthodontics (Dentures, Bridges)	$0 – $275 copay	50%**	50%**
Orthodontics			
• Child (to age 19)	$1,600	50% (deductible waived)	50% (deductible waived)
• Adult	$1,600	50% (deductible waived)	50% (deductible waived)
• Lifetime Maximum Benefit	None	Plan pays up to $1,500	Plan pays up to $1,500

* When utilizing Non-Participating Dentists, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the dentist any difference between the Plan's payment and the dentist's full charge for the services.

** There is a 24-month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

VISION

Plan Benefits	Anthem Blue Cross Blue View Vision	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Once every 12 months	
• Lenses / Contacts	Once every 12 months	
• Frames	Once every 24 months	
Copay	MEMBER RESPONSIBILITY	PLAN PAYS
• Exam	$25 copay	Up to $49
• Fitting for Contacts	Up to $55	Not covered
• Materials	$0 copay	Up to allowance schedule
Prescription Lenses	PLAN PAYS	PLAN PAYS
• Single	100%	Up to $35
• Lined Bifocal	100%	Up to $49
• Lined Trifocal	100%	Up to $74
Frames	Up to $130 + 20% off balance	Up to $50
Contacts (in lieu of lenses and frames)	Up to $130 + 15% off balance	Up to $92

CARRIER CONTACT INFORMATION

	Phone Number	Web Site
MMCHR (Payroll, HR, Benefits Administration)	800.899.6624	Benefits@mmchr.com
MMCHR Online Employee Access	www.MMChr.com/client-login	
Anthem Medical HMO and PPO	800.888.8288	www.anthem.com/ca
Anthem Medical Lumenos HSA	866.207.9878	www.anthem.com/ca
Anthem Dental Complete	877.567.1804	www.anthem.com/ca
Anthem Dental Net DHMO	888.209.7852	www.anthem.com/ca
Anthem Blue View Vision	866.723.0515	www.anthem.com/ca
Anthem Life / AD&D Claims	800.552.2137	www.anthem.com/ca
Anthem Life Conversion / Portability	800.801.6142	www.anthem.com/ca
eflexgroup / TASC (FSA / HSA)	877.933.3539	www.eflexgroup.com

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