Member Benefits Program

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KAISER PERMANENTE

Benefit Sheet

	Kaiser Platinum 90 HMO 0/10 + Child Dental Alt (Broad Network)		Kaiser Platinum 90 HMO 0/20 + Child Dental (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$0		$0	
Family Ded	$0		$0	
Individual OOP Max	$3,000		$4,500	
Family OOP Max	$6,000		$9,000	
Co-insurance	0%		0%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$10/$20		$20/$30	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$10		$20	
Chiropractic Care	$15; 20 visits/yr		Not covered	
Inpatient Hospital	$500/admit		$250/day up to 5 days	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	$500/admit		$250/day up to 5 days	
Mental Health IP	$500/admit		$250/day up to 5 days	
Substance Abuse IP	$500/admit		$250/day up to 5 days	
Outpatient Facility	$300		$125	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	$20/$40		$20/$30	
Advanced Radiology	$150		$100	
Mental Health OP	$10		$20	
Substance Abuse OP	$10		$20	
Emergency Room	$200 (waived if admitted)		$150 (waived if admitted)	
Ambulance	$150		$150	
Urgent Care	$10		$20	
Rx Generic	$5		$5	
Rx Preferred	$15		$20	
Rx Non-Preferred	$15		$20	
Rx Specialty	10%; $250 max/script		10%; $250 max/script	
Rx Mail Order	2x retail (100 day supply)		2x retail (100 day supply)	
Home Health Care	No charge; 100 visits/yr		$20; 100 visits/yr	
Skilled Nursing	$250/admit; 100 days/yr		$150/day up to 5 days; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	10% (base and supplemental)		10% (base and supplemental)	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

Formerly Platinum 0/15

KAISER PERMANENTE

Benefit Sheet

	Kaiser Gold 80 HMO 0/30 + Child Dental Alt (Broad Network)		Kaiser Gold 80 HMO 250/35 + Child Dental (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$0		$250	
Family Ded	$0		$500 (embedded)	
Individual OOP Max	$7,000		$7,800 (incl ded)	
Family OOP Max	$14,000		$15,600 (incl ded)	
Co-insurance	0%		0%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$30/$35		$35/$55 ded waived	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$30		$35 ded waived	
Chiropractic Care	$15; 20 visits/yr		Not covered	
Inpatient Hospital	$600/day up to 5 days		$600/day after ded up to 5 days	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	$600/day up to 5 days		$600/day after ded up to 5 days	
Mental Health IP	$600/day up to 5 days		$600/day after ded up to 5 days	
Substance Abuse IP	$600/day up to 5 days		$600/day after ded up to 5 days	
Outpatient Facility	$320		$335 after ded	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	$30/$40		$35/$55 ded waived	
Advanced Radiology	$250		$250 after ded	
Mental Health OP	$30		$35 ded waived	
Substance Abuse OP	$30		$35 ded waived	
Emergency Room	$250 (waived if admitted)		$250 (waived if admitted) after ded	
Ambulance	$250		$250 after ded	
Urgent Care	$30		$35 ded waived	
Rx Generic	$15		$15 ded waived	
Rx Preferred	$40		$40 ded waived	
Rx Non-Preferred	$40		$40 ded waived	
Rx Specialty	20%; $250 max/script		20% ded waived; $250 max/script	
Rx Mail Order	2x retail (100 day supply)		2x retail (100 day supply)	
Home Health Care	No charge; 100 visits/yr		$30 ded waived; 100 visits/yr	
Skilled Nursing	$300/day up to 5 days; 100 days/yr		$300/day after ded up to 5 days; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	20% (base and supplemental)		20% ded waived/20% after ded (base/supplemental)	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

Formerly Gold 250/25
Replaced Gold 500/30

KAISER PERMANENTE

Benefit Sheet

	NEW Kaiser Gold 80 HMO 1000/40 + Child Dental Alt (Broad Network)		Kaiser Gold 80 HRA HMO 2250/35 + Child Dental (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$1,000		$2,250	
Family Ded	$2,000 (embedded)		$4,500 (embedded)	
Individual OOP Max	$7,800 (incl ded)		$7,800 (incl ded)	
Family OOP Max	$15,600 (incl ded)		$15,600 (incl ded)	
Co-insurance	0%		25%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$40/$60 ded waived		$35/$50 ded waived	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$40 ded waived		$35 after ded	
Chiropractic Care	$15 ded waived; 20 visits/yr		Not covered	
Inpatient Hospital	$600/day after ded up to 5 days		25% after ded	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	$600/day after ded up to 5 days		25% after ded	
Mental Health IP	$600/day after ded up to 5 days		25% after ded	
Substance Abuse IP	$600/day after ded up to 5 days		25% after ded	
Outpatient Facility	$350 ded waived		25% after ded	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	$30/$60 ded waived		25% after ded	
Advanced Radiology	$350 after ded		25% after ded	
Mental Health OP	$40 ded waived		$35 ded waived	
Substance Abuse OP	$40 ded waived		$35 ded waived	
Emergency Room	$350 (waived if admitted) ded waived		25% after ded	
Ambulance	$350 ded waived		25% after ded	
Urgent Care	$40 ded waived		$35 ded waived	
Rx Generic	$20 ded waived		$15 ded waived	
Rx Preferred	$50 after $250		$30 after $100	
Rx Non-Preferred	$50 after $250		$30 after $100	
Rx Specialty	20% after $250; $250 max/script		20% after $100; $250 max/script	
Rx Mail Order	2x retail (100 day supply)		2x retail (100 day supply)	
Home Health Care	No charge; 100 visits/yr		No charge; 100 visits/yr	
Skilled Nursing	$300/day after ded up to 5 days; 100 days/yr		25% after ded; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	20% ded waived/20% after ded (base/supplemental)		50% ded waived/50% after ded (base/supplemental)	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

KAISER PERMANENTE

Benefit Sheet

	Kaiser Silver 70 HMO 1650/55 + Child Dental Alt (Broad Network)		Kaiser Silver 70 HMO 2100/55 + Child Dental Alt (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$1,650		$2,100	
Family Ded	$3,300 (embedded)		$4,200 (embedded)	
Individual OOP Max	$8,200 (incl ded)		$8,200 (incl ded)	
Family OOP Max	$16,400 (incl ded)		$16,400 (incl ded)	
Co-insurance	40%		45%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$55/$80 ded waived		$55/$80 ded waived	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$65 ded waived		$65 ded waived	
Chiropractic Care	$15 ded waived; 20 visits/yr		$15 ded waived; 20 visits/yr	
Inpatient Hospital	40% after ded		45% after ded	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	40% after ded		45% after ded	
Mental Health IP	40% after ded		45% after ded	
Substance Abuse IP	40% after ded		45% after ded	
Outpatient Facility	40% after ded		45% after ded	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	$30/$75 ded waived		$30/$75 ded waived	
Advanced Radiology	$350 after ded		$350 after ded	
Mental Health OP	$55 ded waived		$55 ded waived	
Substance Abuse OP	$55 ded waived		$55 ded waived	
Emergency Room	40% after ded		45% after ded	
Ambulance	40% after ded		45% after ded	
Urgent Care	$55 ded waived		$55 ded waived	
Rx Generic	$20 ded waived		$20 ded waived	
Rx Preferred	$75 after $350		$75 after $500	
Rx Non-Preferred	$75 after $350		$75 after $500	
Rx Specialty	20% after $350; $250 max/script		20% after $500; $250 max/script	
Rx Mail Order	2x retail (100 day supply)		2x retail (100 day supply)	
Home Health Care	No charge; 100 visits/yr		No charge; 100 visits/yr	
Skilled Nursing	40% after ded; 100 days/yr		45% after ded; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	40% ded waived/40% after ded (base/supplemental)		45% ded waived/45% after ded (base/supplemental)	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

Formerly Silver 1800/55

KAISER PERMANENTE

Benefit Sheet

	Kaiser Silver 70 HMO 2250/55 + Child Dental (Broad Network)		NEW Kaiser Silver 70 HMO 2600/55 + Child Dental Alt (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$2,250		$2,600	
Family Ded	$4,500 (embedded)		$5,200 (embedded)	
Individual OOP Max	$8,200 (incl ded)		$8,200 (incl ded)	
Family OOP Max	$16,400 (incl ded)		$16,400 (incl ded)	
Co-insurance	30%		45%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$55/$90 ded waived		$55/$80 ded waived	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$55 ded waived		$65 ded waived	
Chiropractic Care	Not covered		$15 ded waived; 20 visits/yr	
Inpatient Hospital	30% after ded		45% after ded	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	30% after ded		45% after ded	
Mental Health IP	30% after ded		45% after ded	
Substance Abuse IP	30% after ded		45% after ded	
Outpatient Facility	30% after ded		45% after ded	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	$55/$90 ded waived		$30/$75 after ded	
Advanced Radiology	$300 after ded		$350 after ded	
Mental Health OP	$55 ded waived		$55 ded waived	
Substance Abuse OP	$55 ded waived		$55 ded waived	
Emergency Room	30% after ded		45% after ded	
Ambulance	30% after ded		45% after ded	
Urgent Care	$55 ded waived		$55 ded waived	
Rx Generic	$17 ded waived		$20 ded waived	
Rx Preferred	$80 after $300		$75 after ded	
Rx Non-Preferred	$80 after $300		$75 after ded	
Rx Specialty	30% after $300; $250 max/script		45% after ded; $250 max/script	
Rx Mail Order	2x retail (100 day supply)		2x retail (100 day supply)	
Home Health Care	$45 ded waived; 100 visits/yr		No charge; 100 visits/yr	
Skilled Nursing	30% after ded; 100 days/yr		45% after ded; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	30% ded waived/30% after ded (base/supplemental)		45% ded waived/45% after ded (base/supplemental)	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

Formerly Silver 2250/50

KAISER PERMANENTE

Benefit Sheet

	Kaiser Silver 70 HDHP HMO 2500/20% + Child Dental (Broad Network)		NEW Kaiser Bronze 60 HMO 5400/60 + Child Dental Alt (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$2,500 ind only; $2,800 ind w/family		$5,400	
Family Ded	$5,000 (embedded)		$10,800 (embedded)	
Individual OOP Max	$6,850 (incl ded)		$8,200 (incl ded)	
Family OOP Max	$13,700 (incl ded)		$16,400 (incl ded)	
Co-insurance	20%		50%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	20% after ded		$60/$80 ded waived 1st 3 visits	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	20% after ded		$65 ded waived	
Chiropractic Care	Not covered		$15 ded waived; 20 visits/yr	
Inpatient Hospital	20% after ded		50% after ded	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	20% after ded		50% after ded	
Mental Health IP	20% after ded		50% after ded	
Substance Abuse IP	20% after ded		50% after ded	
Outpatient Facility	20% after ded		50% after ded	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	20% after ded		$30/50% after ded	
Advanced Radiology	20% after ded		50% after ded	
Mental Health OP	20% after ded		$60 ded waived 1st 3 visits	
Substance Abuse OP	20% after ded		$60 ded waived 1st 3 visits	
Emergency Room	20% after ded		50% after ded	
Ambulance	20% after ded		50% after ded	
Urgent Care	20% after ded		$60 ded waived 1st 3 visits	
Rx Generic	20% after ded; $250 max/script		$20 ded waived	
Rx Preferred	20% after ded; $250 max/script		50% after ded; $500 max/script	
Rx Non-Preferred	20% after ded; $250 max/script		50% after ded; $500 max/script	
Rx Specialty	20% after ded; $250 max/script		50% after ded; $500 max/script	
Rx Mail Order	N/A		2x retail (100 day supply)	
Home Health Care	20% after ded; 100 visits/yr		50% after ded; 100 visits/yr	
Skilled Nursing	20% after ded; 100 days/yr		50% after ded; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	20% after ded (base and supplemental)		50% after ded (base and supplemental)	
Hospice Services	0% after ded		No charge	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

KAISER PERMANENTE

Benefit Sheet

	Kaiser Bronze 60 HMO 6300/65 + Child Dental (Broad Network)		Kaiser Bronze 60 HDHP HMO 7000/0% + Child Dental (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$6,300		$7,000	
Family Ded	$12,600 (embedded)		$14,000 (embedded)	
Individual OOP Max	$8,200 (incl ded)		$7,000 (incl ded)	
Family OOP Max	$16,400 (incl ded)		$14,000 (incl ded)	
Co-insurance	40%		0%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$65/$95 ded waived 1st 3 visits		0% after ded	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$65 ded waived		0% after ded	
Chiropractic Care	Not covered		Not covered	
Inpatient Hospital	40% after ded		0% after ded	
Inpatient Surgery	N/A		N/A	
Maternity Delivery/IP	40% after ded		0% after ded	
Mental Health IP	40% after ded		0% after ded	
Substance Abuse IP	40% after ded		0% after ded	
Outpatient Facility	40% after ded		0% after ded	
Outpatient Surgery	N/A		N/A	
Lab/X-Ray	$40 ded waived/40% after ded		0% after ded	
Advanced Radiology	40% after ded		0% after ded	
Mental Health OP	$65 ded waived 1st 3 visits		0% after ded	
Substance Abuse OP	$65 ded waived 1st 3 visits		0% after ded	
Emergency Room	40% after ded		0% after ded	
Ambulance	40% after ded		0% after ded	
Urgent Care	$65 ded waived 1st 3 visits		0% after ded	
Rx Generic	$18 after $500		0% after ded	
Rx Preferred	40% after $500; $500 max/script		0% after ded	
Rx Non-Preferred	40% after $500; $500 max/script		0% after ded	
Rx Specialty	40% after $500; $500 max/script		0% after ded	
Rx Mail Order	2x retail (100 day supply)		N/A	
Home Health Care	40% after ded; 100 visits/yr		0% after ded; 100 visits/yr	
Skilled Nursing	40% after ded; 100 days/yr		0% after ded; 100 days/yr	
Infertility Treatment	Not covered		Not covered	
DME	40% after ded (base and supplemental)		0% after ded (base and supplemental)	
Hospice Services	No charge		0% after ded	
Pediatric Vision	No charge; 1 pair/yr		No charge; 1 pair/yr	
Pediatric Dental	Bundled w/copay plan		Bundled w/copay plan	

Formerly Bronze 6900/0

Chiropractic and acupuncture

Combined coverage for chiropractic and acupuncture care is included with the following plans:

- Platinum 90 HMO 0/10 + Child Dental Alt
- Gold 80 HMO 0/30 + Child Dental Alt
- Gold 80 HMO 1000/40 + Child Dental Alt
- Silver 70 HMO 1650/55 + Child Dental Alt
- Silver 70 HMO 2100/55 + Child Dental Alt
- Silver 70 HMO 2600/55 + Child Dental Alt
- Bronze 60 HMO 5400/60 + Child Dental Alt

Services are administered by American Specialty Health Plans of California, Inc®. (ASH Plans).

FEATURES	
Office visit copay	$15 per visit
Office visit limit	20 combined visits per year
Chiropractic appliance benefit	Chiropractic appliances are provided up to a maximum of $50 per year when prescribed and provided by an ASH Plans participating chiropractor as part of your chiropractic care.
X-rays and laboratory tests	$0

Services

Chiropractic services are covered when a participating chiropractor finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders. Acupuncture services are covered when a participating acupuncturist finds that the services are medically necessary to treat or diagnose neuromusculoskeletal disorders, nausea, or pain. You can obtain services from any ASH Plans participating chiropractors and acupuncturists without a referral from a Kaiser Permanente Plan physician.

Office visits: Covered services are limited to medically necessary chiropractic and acupuncture services authorized and provided by ASH Plans participating chiropractors and acupuncturists.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered when prescribed as part of your chiropractic care by a participating chiropractor and provided by an appropriately licensed participating provider that has contracted with ASH Plans to provide those services.

Emergency services: Covered chiropractic services are those emergency services provided for the sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system. Covered acupuncture services are those emergency services provided for the sudden and unexpected treatment of a neuromusculoskeletal disorder, nausea, or pain. These conditions and injuries must manifest themselves by acute symptoms of sufficient severity, including severe pain, such that a reasonable layperson with no special knowledge of health, medicine, chiropractic care, or acupuncture could reasonably expect that a delay of immediate chiropractic care or acupuncture could result in (1) placing your health in serious jeopardy, (2) serious impairment to your bodily functions, or (3) serious dysfunction of any bodily organ or part.

Participating chiropractors and acupuncturists

ASH Plans contracts with participating chiropractors and other participating providers to provide covered chiropractic services, including laboratory tests, X-rays, and chiropractic appliances. ASH Plans

contracts with participating acupuncturists to provide acupuncture care (including adjunctive therapies, such as acupressure, moxibustion, or breathing techniques, when provided during the same course of treatment and in conjunction with acupuncture). You must receive covered services from an ASH Plans participating provider, except for emergency chiropractic and acupuncture services and services that aren't available from participating providers that are previously authorized by ASH Plans. The list of participating chiropractors and acupuncturists is available on the ASH Plans website at **ashlink.com/ash/kp** or from the ASH Plans Member Services Department at **800-678-9133.** The list of participating chiropractors and acupuncturists is subject to change at any time without notice.

How to obtain covered services

To obtain covered services, schedule an initial examination with an ASH Plans participating provider. If additional services are required, your participating chiropractor or acupuncturist will prepare a treatment plan. The ASH Plans Clinical Services Manager will authorize the treatment plan if the services are medically necessary. ASH Plans will disclose to you, upon request, the process that it uses to authorize a treatment plan. If you have questions or concerns, please contact the ASH Plans Member Services Department.

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic and acupuncture benefit, including copays. Please refer to the *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic and acupuncture benefits, including exclusions and limitations, emergency chiropractic services, and emergency acupuncture services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of participating chiropractors and participating acupuncturists available to you. You can obtain covered services from any participating chiropractor or participating acupuncturist without a referral from a Plan physician. Cost sharing is due when you receive covered services. Please see the definitions section of your *Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

Getting assistance

If you have a question or concern regarding the services you received from a participating provider, you may call ASH Plans Member Services at **800-678-9133** (TTY users, call **711**), weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans Member Services
P.O. Box 509002
San Diego, CA 92150-9002

Dispute resolution

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as why you believe a decision was in error or why you're dissatisfied with services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Evidence of Coverage*.

CHILD DENTAL PLAN FOR KAISER PERMANENTE HMO MEDICAL PLANS

Child dental services is one of the essential health benefits required to be provided in conjunction with your Affordable Care Act (ACA) metal medical plan(s). When employees and their dependents enroll in the HMO medical plan(s) you've chosen, we'll also enroll them in a separate child dental plan underwritten by Delta Dental of California. Child dental benefits for HMO members are provided through the DeltaCare USA network.

FEATURES	MEMBER PAYS
DEDUCTIBLE	$0
OUT-OF-POCKET (OOP) MAXIMUM	$350/child $700/multichild
WAITING PERIODS	None
OFFICE VISIT	$0
DIAGNOSTIC AND PREVENTIVE	
Periodic and comprehensive – oral evaluation	$0
Bitewing X-rays	$0
Prophylaxis cleaning	$0
Fluoride treatments	$0
Space maintainers	$0
Sealant repair	$0
PERIODONTICS	
Maintenance	$30
Scaling and root planing	$30
Surgery – osseous (includes flap entry and closure)	$265
RESTORATIVE	
Fillings – primary or permanent amalgam	$25
Composite crowns – resin-based one surface anterior	$30
Crown – porcelain	$300
ENDODONTICS	
Therapeutic pulpotomy	$40
Root canal – anterior	$195
Root canal – molar	$300
PROSTHODONTICS	
Complete denture	$300
Reline maxillary denture – chairside and limitations is "Partial"	$60
Reline maxillary denture – laboratory and limitations is "Partial"	$90
ORAL AND MAXILLOFACIAL SURGERY	
Extraction – erupted tooth or exposed root	$65
Surgical removal of erupted tooth	$120
ORTHODONTICS (MEDICALLY NECESSARY)	$350*

Important information

- To find a dentist, please call Delta Dental at **1-800-422-4234.**
- You choose a Delta Dental dentist for each child. If you don't choose a dentist, we assign one to you.
- As soon as you receive your welcome kit, you can schedule an appointment. You can change your selected network dentist at any time by telephone. Changes received by the 21st of the month will be effective the first day of the following month.
- If you require specialty care, your Delta Dental dentist will coordinate it for you.

*Orthodontics includes medically necessary orthodontia only.

DELTA DENTAL®
Delta Dental Plan of California
deltadentalins.com

KAISER PERMANENTE®

KAISER PERMANENTE PEDIATRIC VISION CARE

(Services only rendered at Kaiser Permanente for Kaiser Permanente Vision Essentials)

Affordable Care Act (ACA)–qualified health plans include vision benefits and medical care from trusted Kaiser Permanente optometrists and ophthalmologists. You can connect vision care to overall health with Vision Essentials by Kaiser Permanente. Because our optometrists and ophthalmologists work with our integrated care system, they're connected to our larger team of medical professionals. Regular eye exams can detect not only vision problems, but symptoms of other important health issues.

Services must be performed and provided by a Kaiser Permanente provider for children who are under the age of 19 and are covered under an ACA metal plan. They'll have their choice of either regular clear eyeglasses or contact lenses from the Value Collection to serve their vision needs.

FEATURES	MEMBER PAYS
ROUTINE VISION EXAM[1]	$0
EYEGLASS OPTION[2]	
Yearly eye exam with refraction	$0
Regular clear eyeglasses (Value Collection frame and lenses only)	$0
CONTACT LENS OPTION[3]	
Yearly eye exam with refraction	$0
Contact lens fitting fees	$0
One pair of standard or disposable contact lenses	$0

[1]Schedule a routine eye exam with a plan optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses **(not subject to the plan deductible)**.

[2]If you prefer to wear eyeglasses rather than contact lenses, we cover one complete pair of eyeglasses (frame and regular eyeglass lenses) from our designated value frame collection **(not subject to the plan deductible)** every 12 months when prescribed by a physician or optometrist and a plan provider puts the lenses into an eyeglass frame.

[3]If you prefer to wear contact lenses rather than eyeglasses, we cover one of the following, including fitting and dispensing, **(not subject to the plan deductible)** when prescribed by a physician or optometrist and obtained at a plan medical office or plan optical sales office:

- Standard contact lenses: one pair of lenses in any 12-month period
- Disposable contact lenses: one 6-month supply for each eye in any 12-month period

Important Information

To find locations, products, and services for metal plans, go to **kp.org/2020**.

For further detailed information on pediatric vision, refer to your *Combined Disclosure Form and Evidence of Coverage*.

KAISER PERMANENTE®

KAISER PERMANENTE®

Rate Areas 1, 3, 5

For effective dates July 1–December 1, 2021

A SEPERATE $20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

Small Business medical plan rates

Age on 2021 effective date	Platinum 90 HMO 0/10* + Child Dental Alt	Platinum 90 HMO 0/20* + Child Dental Formerly 0/15	Gold 80 HMO 0/30* + Child Dental Alt	Gold 80 HMO 250/35* + Child Dental Formerly 250/25 Replaced 500/30	Gold 80 HMO 1000/40* + Child Dental Alt NEW Plan	Gold 80 HRA HMO 2250/35 + Child Dental
0-14†	$336.67	$330.81	$315.62	$298.73	$282.91	$267.20
15†	$365.36	$358.98	$342.44	$324.04	$306.82	$289.70
16†	$376.32	$369.74	$352.69	$333.72	$315.96	$298.31
17†	$387.29	$380.51	$362.94	$343.40	$325.10	$306.92
18†	$399.10	$392.11	$373.98	$353.82	$334.94	$316.18
19	$396.92	$389.71	$371.03	$350.25	$330.79	$311.46
20	$409.16	$401.72	$382.46	$361.05	$340.99	$321.06
21	$421.81	$414.15	$394.29	$372.21	$351.53	$330.99
22	$421.81	$414.15	$394.29	$372.21	$351.53	$330.99
23	$421.81	$414.15	$394.29	$372.21	$351.53	$330.99
24	$421.81	$414.15	$394.29	$372.21	$351.53	$330.99
25	$423.50	$415.81	$395.87	$373.70	$352.94	$332.31
26	$431.93	$424.09	$403.76	$381.15	$359.97	$338.93
27	$442.06	$434.03	$413.22	$390.08	$368.41	$346.88
28	$458.51	$450.18	$428.60	$404.59	$382.12	$359.79
29	$472.00	$463.43	$441.21	$416.51	$393.37	$370.38
30	$478.75	$470.06	$447.52	$422.46	$398.99	$375.67
31	$488.88	$480.00	$456.99	$431.39	$407.43	$383.62
32	$499.00	$489.94	$466.45	$440.33	$415.87	$391.56
33	$505.33	$496.15	$472.36	$445.91	$421.14	$396.52
34	$512.08	$502.78	$478.67	$451.87	$426.76	$401.82
35	$515.45	$506.09	$481.83	$454.84	$429.58	$404.47
36	$518.83	$509.40	$484.98	$457.82	$432.39	$407.12
37	$522.20	$512.72	$488.14	$460.80	$435.20	$409.76
38	$525.57	$516.03	$491.29	$463.78	$438.01	$412.41
39	$532.32	$522.66	$497.60	$469.73	$443.64	$417.71
40	$539.07	$529.28	$503.91	$475.69	$449.26	$423.00
41	$549.20	$539.22	$513.37	$484.62	$457.70	$430.95
42	$558.90	$548.75	$522.44	$493.18	$465.78	$438.56
43	$572.40	$562.00	$535.06	$505.09	$477.03	$449.15
44	$589.27	$578.57	$550.83	$519.98	$491.09	$462.39
45	$609.09	$598.03	$569.36	$537.47	$507.62	$477.95
46	$632.71	$621.22	$591.44	$558.32	$527.30	$496.48
47	$659.29	$647.31	$616.28	$581.77	$549.45	$517.34
48	$689.66	$677.13	$644.67	$608.57	$574.76	$541.17
49	$719.61	$706.54	$672.67	$634.99	$599.72	$564.67
50	$753.35	$739.67	$704.21	$664.77	$627.84	$591.15
51	$786.67	$772.39	$735.36	$694.18	$655.61	$617.29
52	$823.37	$808.42	$769.66	$726.56	$686.20	$646.09
53	$860.49	$844.86	$804.36	$759.31	$717.13	$675.22
54	$900.56	$884.21	$841.82	$794.67	$750.53	$706.66
55	$940.64	$923.55	$879.27	$830.03	$783.92	$738.11
56	$984.08	$966.21	$919.89	$868.37	$820.13	$772.20
57	$1,027.95	$1,009.28	$960.89	$907.08	$856.69	$806.62
58	$1,074.77	$1,055.25	$1,004.66	$948.40	$895.71	$843.36
59	$1,097.97	$1,078.03	$1,026.35	$968.87	$915.04	$861.56
60	$1,144.79	$1,124.00	$1,070.11	$1,010.18	$954.07	$898.30
61	$1,185.28	$1,163.76	$1,107.97	$1,045.92	$987.81	$930.08
62	$1,211.86	$1,189.85	$1,132.81	$1,069.37	$1,009.96	$950.93
63	$1,245.18	$1,222.57	$1,163.95	$1,098.77	$1,037.73	$977.08
64+	$1,265.43	$1,242.45	$1,182.87	$1,116.63	$1,054.59	$992.97

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of $13.99 for Child Dental coverage.

KAISER PERMANENTE®

Rate Areas 1, 3, 5

For effective dates July 1–December 1, 2021

A SEPERATE $20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

Age on 2021 effective date	Silver 70 HMO 1650/55* + Child Dental Alt	Silver 70 HMO 2100/55* + Child Dental Alt Formerly 1800/55	Silver 70 HMO 2250/55* + Child Dental Formerly 2250/50	Silver 70 HMO 2600/55* + Child Dental Alt NEW Plan	Silver 70 HDHP HMO 2500/20%* + Child Dental
0-14†	$257.48	$253.06	$255.75	$249.05	$237.58
15†	$279.13	$274.31	$277.24	$269.95	$257.45
16†	$287.40	$282.44	$285.46	$277.94	$265.05
17†	$295.68	$290.56	$293.68	$285.93	$272.65
18†	$304.59	$299.31	$302.53	$294.53	$280.83
19	$299.51	$294.07	$297.39	$289.14	$275.03
20	$308.74	$303.14	$306.55	$298.06	$283.50
21	$318.29	$312.51	$316.03	$307.27	$292.27
22	$318.29	$312.51	$316.03	$307.27	$292.27
23	$318.29	$312.51	$316.03	$307.27	$292.27
24	$318.29	$312.51	$316.03	$307.27	$292.27
25	$319.56	$313.76	$317.30	$308.50	$293.44
26	$325.93	$320.01	$323.62	$314.65	$299.29
27	$333.57	$327.51	$331.20	$322.02	$306.30
28	$345.98	$339.70	$343.53	$334.01	$317.70
29	$356.17	$349.70	$353.64	$343.84	$327.05
30	$361.26	$354.70	$358.70	$348.76	$331.73
31	$368.90	$362.20	$366.28	$356.13	$338.74
32	$376.54	$369.70	$373.86	$363.51	$345.76
33	$381.31	$374.39	$378.61	$368.11	$350.14
34	$386.41	$379.39	$383.66	$373.03	$354.82
35	$388.95	$381.89	$386.19	$375.49	$357.16
36	$391.50	$384.39	$388.72	$377.95	$359.49
37	$394.05	$386.89	$391.25	$380.41	$361.83
38	$396.59	$389.39	$393.77	$382.86	$364.17
39	$401.68	$394.39	$398.83	$387.78	$368.85
40	$406.78	$399.39	$403.89	$392.70	$373.52
41	$414.42	$406.89	$411.47	$400.07	$380.54
42	$421.74	$414.08	$418.74	$407.14	$387.26
43	$431.92	$424.08	$428.85	$416.97	$396.61
44	$444.65	$436.58	$441.50	$429.26	$408.30
45	$459.61	$451.27	$456.35	$443.70	$422.04
46	$477.44	$468.77	$474.05	$460.91	$438.41
47	$497.49	$488.46	$493.96	$480.27	$456.82
48	$520.41	$510.96	$516.71	$502.39	$477.86
49	$543.01	$533.15	$539.15	$524.21	$498.62
50	$568.47	$558.15	$564.43	$548.79	$522.00
51	$593.61	$582.84	$589.40	$573.07	$545.09
52	$621.31	$610.02	$616.89	$599.80	$570.51
53	$649.31	$637.52	$644.70	$626.84	$596.23
54	$679.55	$667.21	$674.73	$656.03	$624.00
55	$709.79	$696.90	$704.75	$685.22	$651.77
56	$742.57	$729.09	$737.30	$716.87	$681.87
57	$775.68	$761.59	$770.17	$748.83	$712.27
58	$811.01	$796.28	$805.25	$782.93	$744.71
59	$828.51	$813.47	$822.63	$799.83	$760.78
60	$863.84	$848.16	$857.71	$833.94	$793.23
61	$894.40	$878.16	$888.05	$863.44	$821.28
62	$914.45	$897.85	$907.96	$882.80	$839.70
63	$939.60	$922.54	$932.92	$907.07	$862.79
64+	$954.87	$937.53	$948.09	$921.81	$876.81

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of $13.99 for Child Dental coverage.

KAISER PERMANENTE®

Rate Areas 1, 3, 5

For effective dates July 1–December 1, 2021

A SEPERATE $20.00 MONTHLY ADMINISTRATION FEE WILL BE ADDED TO CALCULATE YOUR TOTAL MONTHLY RATE

Small Business medical plan rates

Age on 2021 effective date	Bronze 60 HMO 5400/60* + Child Dental Alt NEW Plan	Bronze 60 HMO 6300/65* + Child Dental	Bronze 60 HDHP HMO 7000/0* + Child Dental Formerly 6900/0
0-14†	$216.19	$220.24	$207.06
15†	$234.17	$238.57	$224.23
16†	$241.04	$245.58	$230.79
17†	$247.91	$252.59	$237.35
18†	$255.31	$260.14	$244.42
19	$248.72	$253.70	$237.49
20	$256.39	$261.52	$244.81
21	$264.32	$269.60	$252.38
22	$264.32	$269.60	$252.38
23	$264.32	$269.60	$252.38
24	$264.32	$269.60	$252.38
25	$265.37	$270.68	$253.39
26	$270.66	$276.07	$258.44
27	$277.00	$282.55	$264.50
28	$287.31	$293.06	$274.34
29	$295.77	$301.69	$282.42
30	$300.00	$306.00	$286.46
31	$306.34	$312.47	$292.51
32	$312.69	$318.94	$298.57
33	$316.65	$322.99	$302.36
34	$320.88	$327.30	$306.40
35	$323.00	$329.46	$308.41
36	$325.11	$331.61	$310.43
37	$327.23	$333.77	$312.45
38	$329.34	$335.93	$314.47
39	$333.57	$340.24	$318.51
40	$337.80	$344.55	$322.55
41	$344.14	$351.02	$328.60
42	$350.22	$357.23	$334.41
43	$358.68	$365.85	$342.49
44	$369.25	$376.64	$352.58
45	$381.67	$389.31	$364.44
46	$396.48	$404.41	$378.58
47	$413.13	$421.39	$394.48
48	$432.16	$440.80	$412.65
49	$450.93	$459.94	$430.57
50	$472.07	$481.51	$450.76
51	$492.95	$502.81	$470.70
52	$515.95	$526.27	$492.66
53	$539.21	$549.99	$514.86
54	$564.32	$575.60	$538.84
55	$589.43	$601.22	$562.82
56	$616.65	$628.99	$588.81
57	$644.14	$657.03	$615.06
58	$673.48	$686.95	$643.08
59	$688.02	$701.78	$656.96
60	$717.36	$731.71	$684.97
61	$742.73	$757.59	$709.20
62	$759.38	$774.57	$725.10
63	$780.27	$795.87	$745.04
64+	$792.96	$808.80	$757.14

†HMO 0-14, 15, 16, 17 and 18 age rates include the cost of $13.99 for Child Dental coverage.

Western Health Advantage

Benefit Sheet

	WHA GATEWAY 30 Platinum 90 HMO (Broad Network)		WHA GATEWAY 70 Platinum 90 HMO (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$0		$0	
Family Ded	$0		$0	
Individual OOP Max	$4,000		$4,000	
Family OOP Max	$8,000		$8,000	
Co-insurance	0%		30%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$30/$30		$20/$20	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$30		$20	
Chiropractic Care	$15; 20 visits/yr		$15; 20 visits/yr	
Inpatient Hospital	$300/day; 3 days/admit		30%	
Inpatient Surgery	No charge		No charge	
Maternity Delivery/IP	$300/day; 3 days/admit		30%	
Mental Health IP	$125/$300/day; 3 days/admit (RTC/Hospital)		30%	
Substance Abuse IP	$125/$300/day; 3 days/admit (RTC/Hospital)		30%	
Outpatient Facility	$100		$100	
Outpatient Surgery	No charge		No charge	
Lab/X-Ray	No charge		No charge	
Advanced Radiology	$150		$150	
Mental Health OP	$30		$20	
Substance Abuse OP	$30		$20	
Emergency Room	$150 (waived if admitted)		$150 (waived if admitted)	
Ambulance	No charge		No charge	
Urgent Care	$50		$50	
Rx Generic	$5		$5	
Rx Preferred	$30		$30	
Rx Non-Preferred	$50		$50	
Rx Specialty	20%; $250 max/30-day supply		20%; $250 max/30-day supply	
Rx Mail Order	2.5x retail copay		2.5x retail copay	
Home Health Care	No charge; 100 visits/yr		No charge; 100 visits/yr	
Skilled Nursing	$300/day; 3 days/admit; 100 days/benefit period		30%; 100 days/benefit period	
Infertility Treatment	Refer to carrier		Refer to carrier	
DME	20%		20%	
Hospice Services	No charge		No charge	
Pediatric Vision	No charge		No charge	
Pediatric Dental	No charge		No charge	

Western Health Advantage

Benefit Sheet

	WHA GATEWAY 4010 Gold 80 HMO (Broad Network)		WHA GATEWAY 2400 Gold 80 HDHP HMO (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$1,000		$2,400 ind only; $2,800 ind w/family	
Family Ded	$2,000 (embedded)		$4,800 (embedded)	
Individual OOP Max	$6,750 (incl ded)		$4,800 (incl ded)	
Family OOP Max	$13,500 (incl ded)		$9,600 (incl ded)	
Co-insurance	0%		0%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$40/$40 ded waived		0% after ded	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$40 ded waived		0% after ded	
Chiropractic Care	$15 ded waived; 20 visits/yr		0% after ded; 20 visits/yr	
Inpatient Hospital	$500/day after ded; 5 days/admit		0% after ded	
Inpatient Surgery	No charge		0% after ded	
Maternity Delivery/IP	$500/day after ded; 5 days/admit		0% after ded	
Mental Health IP	$125/$500/day after ded; 5 days/admit (RTC/Hospital)		0% after ded	
Substance Abuse IP	$125/$500/day after ded; 5 days/admit (RTC/Hospital)		0% after ded	
Outpatient Facility	$500 after ded		0% after ded	
Outpatient Surgery	No charge		0% after ded	
Lab/X-Ray	No charge/$40 ded waived		0% after ded	
Advanced Radiology	$300 ded waived		0% after ded	
Mental Health OP	$40 ded waived		0% after ded	
Substance Abuse OP	$40 ded waived		0% after ded	
Emergency Room	$300 (waived if admitted) after ded		0% after ded	
Ambulance	No charge		0% after ded	
Urgent Care	$50 ded waived		0% after ded	
Rx Generic	$10 ded waived		0% after ded	
Rx Preferred	$50 after $500		$30 after ded	
Rx Non-Preferred	$75 after $500		$50 after ded	
Rx Specialty	20% after $500; $250 max/30-day supply		20% after ded; $250 max/30-day supply	
Rx Mail Order	2.5x retail copay		2.5x retail copay	
Home Health Care	No charge; 100 visits/yr		0% after ded; 100 visits/yr	
Skilled Nursing	$500/day after ded; 5 days/admit; 100 days/benefit period		0% after ded; 100 days/benefit period	
Infertility Treatment	Refer to carrier		Refer to carrier	
DME	20% ded waived		0% after ded	
Hospice Services	No charge		0% after ded	
Pediatric Vision	No charge		No charge	
Pediatric Dental	No charge		No charge	

Formerly Gateway 2000

Western Health Advantage

Benefit Sheet

	WHA GATEWAY 5020 Silver 70 HMO (Broad Network)		WHA GATEWAY 7000 Bronze 60 HDHP HMO (Broad Network)	
Benefit	**In Net**	**Out Net**	**In Net**	**Out Net**
Individual Ded	$2,000		$7,000	
Family Ded	$4,000 (embedded)		$14,000 (embedded)	
Individual OOP Max	$7,800 (incl ded)		$7,000 (incl ded)	
Family OOP Max	$15,600 (incl ded)		$14,000 (incl ded)	
Co-insurance	30%		0%	
Lifetime Max	Unlimited		Unlimited	
PC/Specialist	$50/$50 ded waived		0% after ded	
Adult Preventive Care	No charge		No charge	
Child Preventive Care	No charge		No charge	
Pre/Postnatal Care	No charge		No charge	
Physical Therapy	$50 ded waived		0% after ded	
Chiropractic Care	$15 ded waived; 20 visits/yr		0% after ded; 20 visits/yr	
Inpatient Hospital	30% after ded		0% after ded	
Inpatient Surgery	No charge		0% after ded	
Maternity Delivery/IP	30% after ded		0% after ded	
Mental Health IP	30% after ded		0% after ded	
Substance Abuse IP	30% after ded		0% after ded	
Outpatient Facility	$500 after ded		0% after ded	
Outpatient Surgery	0% after ded		0% after ded	
Lab/X-Ray	$50/$80 ded waived		0% after ded	
Advanced Radiology	$500 after ded		0% after ded	
Mental Health OP	$50 ded waived		0% after ded	
Substance Abuse OP	$50 ded waived		0% after ded	
Emergency Room	30% after ded		0% after ded	
Ambulance	No charge		0% after ded	
Urgent Care	$50 ded waived		0% after ded	
Rx Generic	$25 ded waived		0% after ded	
Rx Preferred	$50 after $500		0% after ded	
Rx Non-Preferred	$75 after $500		0% after ded	
Rx Specialty	30% after $500; $250 max/30-day supply		0% after ded	
Rx Mail Order	2.5x retail copay		0% after ded	
Home Health Care	No charge; 100 visits/yr		0% after ded; 100 visits/yr	
Skilled Nursing	30% after ded; 100 days/benefit period		0% after ded; 100 days/benefit period	
Infertility Treatment	Refer to carrier		Refer to carrier	
DME	20% ded waived		0% after ded	
Hospice Services	No charge		0% after ded	
Pediatric Vision	No charge		No charge	
Pediatric Dental	No charge		No charge	

Formerly Gateway 6900/0

Western Health Advantage

DeltaCare® USA

PEDIATRIC DENTAL

ESSENTIAL HEALTH BENEFIT (EHB) | Services under the pediatric dental benefit are covered as described below for WHA members under 19 years of age. This is a combined benefit with your medical plan. See your WHA copayment summary.

DeltaCare USA[1] provides quality dental benefits at an affordable cost in this easy-to-use plan. The DeltaCare USA program encourages you to visit the dentist regularly to keep a healthy smile.

PLAN BENEFIT HIGHLIGHTS

- Posterior composites
- Additional cleanings
- Defined fees for metal upgrades
- Unlimited benefits[2]
- General anesthesia and IV sedation covered

CONVENIENT COPAYMENT SCHEDULE

While the benefits shown at right represent the most frequently used services covered under the plan, DeltaCare USA plans offer even more great features[3]. Plus, you don't have to worry about annual deductibles or benefit maximums for covered services—just pay the copayment. Copayments (where applicable) are paid to the DeltaCare USA dentist at the time of treatment.

FIND A PROVIDER

Upon enrollment, you'll choose a DeltaCare USA dentist from the nationwide network. You must visit your selected primary care dentist to receive benefits[2].

To locate a participating provider in your area:

visit deltadentalins.com
call 800.422.4234 (TTY/TDD 711)
Monday – Friday, 5 a.m. to 6 p.m.

DELTA DENTAL®

DeltaCare USA — PEDIATRIC BENEFITS[3]	Copayment
Diagnostic Services	
Periodic oral examinations	$0
X-rays	$0
Preventive Services	
Teeth cleaning (prophylaxis)	$0
Topical fluoride: child	$0
Restorative Services: Filling – Permanent	
Amalgam-three surfaces: primary or permanent	$40
Stainless steel crowns: primary teeth	$65
Oral Surgery Services	
Simple extraction of erupted tooth or exposed root	$65
Surgical extraction of erupted tooth	$120
Impaction: soft tissue	$95
Impaction: partial bony	$145
Impaction: full bony	$160
Endodontic Services	
Pulp cap: direct	$20
Root canal: anterior	$195
Root canal: bicuspid	$235
Root canal: molar	$300
Periodontic Services	
Gingivectomy: one to three teeth per quadrant	$50
Gingivectomy: four or more contiguous teeth per quadrant	$150
Scaling/root planing: one to three teeth per quadrant	$55
Prosthodontic Services	
Crown: porcelain fused to predominantly base metal	$300
Post/core prefabrication	$90
Complete denture	$300
Partial denture	$300
Denture reline: chair side	$60
Orthodontia	
24 months of orthodontic services	$1,000
Other Services	
Office visit: after hours	$45
Local anesthesia	$15

1 DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company.
2 Services are covered only when performed by your selected primary care DeltaCare USA dentist, unless otherwise pre-authorized by Delta Dental of California.
3 This sample of copayments is only a summary of the plan coverage. Upon enrollment, the DeltaCare USA plan will make available a complete list of covered services and copayments, along with any limitations and exclusions that apply.

Western Health Advantage

PEDIATRIC VISION

ESSENTIAL HEALTH BENEFIT (EHB)

Services and eyewear under the pediatric vision benefit are covered as described below for WHA members under 19 years of age. This is a combined benefit with your medical plan. See your WHA copayment summary.

EYE EXAMINATION BENEFITS

Examinations and fittings are covered under your medical plan with a WHA participating provider.

- One comprehensive eye examination per year is covered at no cost.
- Annual eye exams do not require a referral from your primary care physician (PCP), but members must select a WHA participating provider.
- Other than the annual eye exam, all vision exams require a referral from your PCP.

FIND A PROVIDER: EYE EXAM

To schedule an eye exam, locate a participating provider in your area by searching WHA's online directory at mywha.org.com/directory.

EYEWEAR BENEFITS

Glasses, lenses, elective contact lenses and low vision devices are generally covered through MESVision, except as specifically noted below.

- The following are covered by MES at no cost:
  - One pair of glasses with standard lenses; or
  - One pair of standard hard or six pairs of standard soft contact lenses per calendar year instead of glasses
  - One pair of medically necessary contact lenses (except as noted below).

If your WHA participating provider has determined you need contact lenses, they will be covered by MES or by WHA, as listed below:

- Medically necessary contact lenses require prior authorization and are covered by MES for the following conditions: Keratoconus (visual acuity to 20/40), Pathological Myopia, Hyperopia, Anisometropia (visual acuity to 20/60), Corneal Disorders, and Irregular Astigmatism.
- Medically necessary contact lenses require prior authorization and are covered by WHA for the following conditions: Aniseikonia, Aniridia, Post-traumatic Disorders, including Avoidance of Diplopia or Suppression, and Aphakia. To obtain medically necessary contact lenses through WHA, you must obtain a referral from your PCP.
- Expanded benefit for Aniridia and Aphakia: Two medically necessary contact lenses per eye are covered in any 12-month period to treat Aniridia. Six medically necessary contact lenses per eye are covered per calendar year to treat Aphakia including fitting and dispensing, for members through nine years of age.
- For children with low vision (defined as a significant loss of vision but not total blindness), one pair of high-power spectacles per calendar year and a lifetime maximum of one magnifier and one telescope are covered at no charge, with prior authorization.

FIND A PROVIDER: EYEWEAR

As described, most glasses and contact lenses benefits and low vision devices are provided by MES. To obtain glasses, contacts or low vision devices through MES under the pediatric vision benefit, you *must obtain* your eyewear from an MES participating provider. It is your responsibility to identify yourself or the member as having an MES plan.

MES Vision®

Customer Service Department

Monday – Friday
8 a.m. to 5 p.m.
call 800.877.6372
visit mesvision.com

Western Health Advantage

Rating Areas 1 and 3

Parts of Colusa, El Dorado, Placer, Sacramento and Yolo County

Small Group Rates by Age and Plan

Plan Name / Age Band	Gateway 30 Platinum 90 HMO	Gateway 70 Platinum 90 HMO	Gateway 4010 Gold 80 HMO	Gateway 2400 Gold 80 HDHP HMO Formerly Gateway 2000	Gateway 5020 Silver 70 HMO	Gateway 7000 Bronze 60 HDHP HMO Formerly Gateway 6900
0 - 14	$263.11	$249.95	$227.30	$218.52	$197.04	$191.93
15	$286.50	$272.17	$247.51	$237.94	$214.55	$208.99
16	$295.44	$280.67	$255.23	$245.37	$221.25	$215.51
17	$304.39	$289.16	$262.96	$252.80	$227.95	$222.03
18	$314.02	$298.31	$271.28	$260.80	$235.16	$229.06
19	$323.65	$307.46	$279.60	$268.79	$242.37	$236.08
20	$333.62	$316.93	$288.21	$277.08	$249.84	$243.36
21-24	$343.94	$326.74	$297.13	$285.65	$257.57	$250.89
25	$345.32	$328.04	$298.31	$286.79	$258.60	$251.89
26	$352.19	$334.58	$304.26	$292.50	$263.75	$256.91
27	$360.45	$342.42	$311.39	$299.36	$269.93	$262.93
28	$373.86	$355.16	$322.98	$310.50	$279.98	$272.71
29	$384.87	$365.62	$332.48	$319.64	$288.22	$280.74
30	$390.37	$370.85	$337.24	$324.21	$292.34	$284.76
31	$398.63	$378.69	$344.37	$331.07	$298.52	$290.78
32	$406.88	$386.53	$351.50	$337.92	$304.70	$296.80
33	$412.04	$391.43	$355.96	$342.21	$308.57	$300.56
34	$417.54	$396.66	$360.71	$346.78	$312.69	$304.58
35	$420.29	$399.27	$363.09	$349.06	$314.75	$306.58
36	$423.05	$401.89	$365.47	$351.35	$316.81	$308.59
37	$425.80	$404.50	$367.84	$353.63	$318.87	$310.60
38	$428.55	$407.11	$370.22	$355.92	$320.93	$312.60
39	$434.05	$412.34	$374.97	$360.49	$325.05	$316.62
40	$439.56	$417.57	$379.73	$365.06	$329.17	$320.63
41	$447.81	$425.41	$386.86	$371.91	$335.35	$326.65
42	$455.72	$432.93	$393.69	$378.48	$341.28	$332.42
43	$466.73	$443.38	$403.20	$387.62	$349.52	$340.45
44	$480.48	$456.45	$415.09	$399.05	$359.82	$350.49
45	$496.65	$471.81	$429.05	$412.48	$371.93	$362.28
46	$515.91	$490.10	$445.69	$428.47	$386.35	$376.33
47	$537.58	$510.69	$464.41	$446.47	$402.58	$392.13
48	$562.34	$534.21	$485.80	$467.03	$421.12	$410.20
49	$586.76	$557.41	$506.90	$487.31	$439.41	$428.01
50	$614.28	$583.55	$530.67	$510.17	$460.02	$448.08
51	$641.45	$609.36	$554.14	$532.73	$480.36	$467.90
52	$671.37	$637.79	$579.99	$557.58	$502.77	$489.73
53	$701.64	$666.54	$606.14	$582.72	$525.44	$511.81
54	$734.31	$697.58	$634.37	$609.86	$549.91	$535.64
55	$766.99	$728.62	$662.59	$636.99	$574.38	$559.47
56	$802.41	$762.28	$693.20	$666.42	$600.91	$585.32
57	$838.18	$796.26	$724.10	$696.12	$627.69	$611.41
58	$876.36	$832.52	$757.08	$727.83	$656.28	$639.26
59	$895.28	$850.50	$773.42	$743.54	$670.45	$653.06
60	$933.45	$886.76	$806.40	$775.25	$699.04	$680.90
61	$966.47	$918.13	$834.93	$802.67	$723.76	$704.99
62	$988.14	$938.71	$853.64	$820.67	$739.99	$720.79
63	$1,015.31	$964.53	$877.12	$843.23	$760.34	$740.61
64 and over	$1,031.82	$980.21	$891.38	$856.94	$772.70	$752.66

Delta Dental Plan Options through the Associations

Effective Date: December 01, 2021 - November 30, 2022

Insurance Carrier	DeltaCare USA	Delta Dental
Plan Name	Plan 11B	Fee For Service
Plan Type	HMO	DPO
Provider Network	DeltaCare USA Network ONLY	PPO or Premier Network
Calendar Year Maximum	Unlimited	$1,000
Deductible:	None	Single $50/Family $ 150
Waived for Preventive	Not Applicable	Yes
Diagnostic		*"Delta Pays"* (A)
Office Visit	$20 copay	$26.00
Periodic Oral Evaluation	No Charge	$17.00
Comprehensive Oral Evaluation	No Charge	$22.00
Bitewing X-rays	No Charge	$12.00 - $26.00
Other X-rays	No Charge	$5.00 - $50.00
Preventive		*"Delta Pays"* (A)
Cleanings Adult	No Charge	$40.00
	Additional Cleanings: $45.00	Not Applicable
Child through Age 13	No Charge	$32.00
	Additional Cleanings: $35.00	Not Applicable
		"Delta Pays" (A)
Restorative	No Charge - $240 copay	$53.00 - $148.00
Oral Surgery	No Charge - $110 copay	$26.00 - $175.00
Endodontics (Root Canals)	No Charge - $250 copay	$50.00 - $402.00
Periodontics (Deep Cleaning)	$80 copay - $280 copay	$39.00 - $448.00
		"Delta Pays" (A)
Waiting Period	None	None
Crowns	$55 copay - $240 copay	$343.00 - $391.00
Prosthodontics, Removable	$20 copay - $210 copay	$255.00 - $676.00
Prosthodontics, Fixed	$40 copay - $240 copay	$191.00 - $605.00
Orthodontia		
Pretreatment/Post Treatment	$200 copay / $70 copay	NOT COVERED
Limited Treatment Child to 19	$950 copay	
Limited Treatment 19 to Adult	$1,150 copay	
Comprehensive Treatment Child to 19	$1,700 copay	
Comprehensive Treatment 19 to Adult	$1,900 copay	
Monthly Premium Rate		
Subscriber Only	$38.80	$55.84
Subscriber+1	$58.47	$98.45
Subscriber+2 or more	$82.42	$129.24

(A) For each procedure, you are responsible for the portion of the dentist's fee that is more than the amount listed in the "Delta Dental Pays" column.

Vision Plan through Associations

Effective December 01, 2021 - November 30, 2022

MEDICAL EYE SERVICES (MES) 12/12/24 PLAN		
Vision Benefits	**In-Network**	**Out-of-Network**
Deductible **Exams** **Material**	 **$10 deductible** **$25 deductible**	 **$10 deductible** **$25 deductible**
Exam	**1 comprehensive exam in any 12 consecutive months**	
Comprehensive Exam	**No Charge**	**Up to $40**
Lenses (per pair)	**1 pair of standard lenses in any 12 consecutive months**	
Frames	**1 standard frame in any 24 consecutive months**	
	Up to retail cost of $130	**Up to $75**
Contact Lenses *** Contact lenses are in lieu of lenses and frames**	**1 pair of standard lenses in any 12 consecutive months**	
Cosmetic/Convenience **Medically Necessary**	**Up to $130** **No Charge**	**Up to $130** **Up to $250**

Monthly Premium Rates			
	Subscriber	**Subscriber & Spouse OR Subscriber & (1) Child**	**Subscriber & Family**
Monthly Rates	**$8.59**	**$15.66**	**$21.57**

Other Services:

Life Insurance Options, Long Term Disability Plans, Medicare Supplements, Prescription Drug Plans