

This benefit comparison chart is for comparative purposes and only illustrates the in-network benefits for each CalCPA Health medical plan. Please see the Plan Document or Summary Plan Description for complete coverage details located at [www.calcpahealth.com](http://www.calcpahealth.com) or by contacting Banyan Administrators at (877) 480-7923.

Benefit*	PPO 10	PPO 15	PPO 25	PPO 35	PPO 40	PPO 45	PPO Saver	PPO Saver HRA	HSA 1500 PPO	HSA 2500 PPO	HSA 3500 PPO	HMO 10	HMO 20
<b>Metal Tier</b>	Platinum	Gold	Gold	Silver	Silver	Silver	Bronze	Silver	Silver	Silver	Bronze	Platinum	Gold
<b>Medical Deductible</b> <sup>†</sup> (Annual Member/Family)	\$250/ \$500	\$500/ \$1,000	\$500/ \$1,000	\$1,000/ \$2,000	\$1,500/ \$3,000	\$1,500/ \$3,000	\$5,000/ \$10,000 <sup>↓</sup>	\$5,000/ \$10,000 <sup>↓</sup>	\$1,500/ \$3,000	\$2,500/ \$5,000	\$3,500/ \$7,000	\$0	\$0
<b>Prescription Drug Deductible</b> (Annual Member/Family)	\$150/ \$300 <sup>↓</sup>	\$150/ \$300 <sup>↓</sup>	\$250/ \$500 <sup>↓</sup>	\$250/ \$500 <sup>↓</sup>	\$250/ \$500 <sup>↓</sup>	\$250/ \$500 <sup>↓</sup>						\$150/ \$300 <sup>↓</sup>	\$150/ \$300 <sup>↓</sup>
<b>Emergency Room Deductible</b> (waived if admitted)	\$100/ incident	\$150/ incident	\$250/ incident	\$250/ incident	\$250/ incident	\$250/ incident	\$300/ incident	\$300/ incident	n/a	n/a	n/a	\$100/visit	\$250/visit
<b>Inpatient Stay Deductible</b> (per non-authorized admit)	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	\$250	n/a	n/a
<b>Out-of-Pocket Maximum</b> (Annual Member/Family) <sup>‡</sup>	\$2,500/ \$5,000	\$4,000/ \$8,000	\$4,500/ \$9,000	\$6,850/ \$13,700	\$6,000/ \$12,000	\$6,600/ \$13,200	\$6,850/ \$13,700	\$6,600/ \$13,200	\$4,500/ \$9,000	\$5,000/ \$10,000	\$6,550/ \$13,100	\$1,750/ \$3,500	\$6,350/ \$12,700
<b>Office Visit Copay</b>	\$10	\$15 <sup>#</sup>	\$25 <sup>#</sup>	\$35 <sup>#</sup>	\$40 <sup>#</sup>	\$45	\$45 <sup>  </sup>	\$45 <sup>  </sup>	30%	15%	30%	\$10	\$35
<b>Specialist Visit Copay</b>	\$20	\$30 <sup>#</sup>	\$25 <sup>#</sup>	\$70 <sup>#</sup>	\$60 <sup>#</sup>	\$65	\$65 <sup>  </sup>	\$65 <sup>  </sup>	30%	15%	30%	\$10	\$65
<b>Urgent Care Copay</b>	\$10	\$15 <sup>#</sup>	\$25 <sup>#</sup>	\$35 <sup>#</sup>	\$40 <sup>#</sup>	\$45	\$120 <sup>  </sup>	\$120 <sup>  </sup>	30%	15%	30%	\$10	\$35
<b>Preventive Care/Immunizations</b> (deductible waived)	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge	No charge
<b>Maternity Care</b>	10%	20%	30%	40%	40%	50%	10%	10%	30%	15%	30%	\$10	\$35
<b>Lab Tests/X-Rays/Diagnostic Imaging</b>	10%	20%	30%	40%	40%	50%	10%	10%	30%	15%	30%	No charge	\$35
<b>Emergency Room</b>	10%	20%	30%	40%	40%	50%	10%	10%	30%	15%	30%	No charge	No charge
<b>Inpatient Hospital</b>	10%	20%	30%	40%	40%	50%	10%	10%	30%	15%	30%	No charge	20%
<b>Outpatient Hospital/Surgical Visit</b>	10%	20%	30%	40%	40%	50%	10%	10%	30%	15%	30%	No charge	No charge

**Prescription Drug Benefits (30-day supply for retail and 90-day supply at 2x copay for mail-order)**

Generic <sup>↑</sup>	\$10	\$10	\$10	\$10	\$10	\$10	\$19	\$19	30%	15%	30%	\$10	\$15
Brand Formulary	\$30	\$30	\$30	\$35	\$30	\$30	\$50	\$50	30%	15%	30%	\$25	\$35
Brand non-Formulary	\$60	\$60	\$60	\$60	\$60	\$60	\$75	\$75	30%	15%	30%	\$45	\$70
Specialty/Injectible	30%	30%	30%	30%	30%	30%	30%	30%	30%	15%	30%	30%	30%

\*Mental Health and Substance Abuse has the same coverage as medical.

<sup>†</sup>Unless stated otherwise, all services are subject to the Annual Deductible and must be satisfied before the plan begins to pay benefits. HSA plans do not include an embedded per-member deductible in a family contract and the family aggregate deductible must be satisfied before the plan begins to pay benefits. The HSA 3500 plan includes a maximum in-network deductible of \$6,850 per member in a family contract.

<sup>‡</sup>Includes Deductible and all copayments/coinsurance amounts. HSA plans do not include an embedded per-member OOP limit and the family aggregate OOP must be met before the OOP limit has been reached. HSA plans have a maximum in-network OOP limit of \$6,850 per member in a family contract.

<sup>#</sup>Deductible is waived for first in-network six visits; 6-visit limit applies to PCP, Specialist and Urgent Care combined.

<sup>||</sup>Deductible is waived for first three in-network visits; 3-visit limit applies to PCP, Specialist, and Urgent Care combined.

<sup>↓</sup>Waived for generic drugs.

<sup>↑</sup>Generic mail order: 90-day supply at 1x copay