COVERED CALIFORNIA SMALL BUSINESS

2020 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Platinum (90%)	•Health Net 0/15 (PPO) •Blue Shield 0/15(PPO) •Sharp 0/15 (Performance HMO)	(OON) = Out of Network •Health Net 0/15 (OON) •Blue Shield 0/15 (OON)	•Kaiser 0/15 (HMO) •Blue Shield 0/15 (Trio HMO) •Oscar 90 0/15 (EPO) •Sharp 0/15 (Premier HMO)	(OON) = Out of Network •Health Net 250/15 Alt (EnhancedCare PPO)		•Kaiser 0/10 Alt (HMO)
Service Type	**In-Network**	**Out-of- Network**	**In-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Individual Deductible (if any)	$0	$1,000	$0	$250	$1,000	$0
Family Deductible (if any)	$0	$2,000	$0	$500	$2,000	$0
Preventive Care/ Screening/Immunization	No Charge	100% Health Net: 50% Coinsurance after deductible	No Charge	No Charge	100%	No Charge
Primary Care Visit to treat an injury, illness, or Condition	$15	50% Coinsurance after deductible	$15	$15	50% Coinsurance after deductible	$10
Other Practitioner Office Visit	$15	50% Coinsurance after deductible	$15	$15	50% Coinsurance after deductible	$10
Specialist Visit	$30	50% Coinsurance after deductible	$30	$30	50% Coinsurance after deductible	$20
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	50% Coinsurance after deductible	No Charge
Urgent Care	$15	50% Coinsurance after deductible	$15	$30	50% Coinsurance after deductible	$10
Laboratory Tests	$15	50% Coinsurance after deductible	$15	$30	50% Coinsurance after deductible	$20
X-Ray and Diagnostic Imaging	$30	50% Coinsurance after deductible	$30	$30	50% Coinsurance after deductible	$40
Emergency Room Facility Fee (waived if admitted)	$150	$150	$150	10% Coinsurance after deductible	10% Coinsurance after deductible	$200
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	10% Coinsurance after deductible	10% Coinsurance after deductible	No Charge
Emergency medical transportation	$150	$150	$150	10% Coinsurance after deductible	10% Coinsurance after deductible	$150
Outpatient Surgery Facility Fee (e.g.,ASC)	10%	50% Coinsurance after deductible	$100	10% Coinsurance after deductible	50% Coinsurance after deductible	$300
Outpatient Physician/Surgeon Fee	10%	50% Coinsurance after deductible	$25	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge
Outpatient Visit	10%	50% Coinsurance after deductible	10%	10% Coinsurance after deductible	50% Coinsurance after deductible	$20
Inpatient Physician/Surgeon Fee	10%	50% Coinsurance after deductible	No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge
Inpatient Facility Fee (e.g. hospital room)	10%	50% Coinsurance after deductible	$250 Copay per day (up to 5 days)	10% Coinsurance after deductible	50% Coinsurance after deductible	$500 per admission
Durable Medical Equipment	10%	50% Coinsurance after deductible	10%	10% Coinsurance after deductible	100%	10%
Imaging (CT/PET scans, MRIs)	10%	50% Coinsurance after deductible	$75	10% Coinsurance after deductible	50% Coinsurance after deductible	$150
Tier 1 (Generic Drugs)	$5	100%	$5 Blue Shield: Level A $5, Level B $10	$10	100%	$5
Tier 2 (Preferred Brand Drugs)	$15	100%	$15 Blue Shield: Level A $15, Level B $30	$35	100%	$15
Tier 3 (Nonpreferred Brand Drugs)	$25	100%	$25 Kaiser:$15 Blue Shield: Level A $25, Level B $45	$60	100%	$15
Tier 4 (Specialty Drugs)	10% (up to $250 per script)	100%	10% (up to $250 per script)	10% (up to $250)	100%	10% (up to $250 per script)
Mental/Behavior Health Outpatient Office Visits	$15	50% Coinsurance after deductible	$15 Sharp: No Charge	$15	50% Coinsurance after deductible	$10
Mental/Behavior Health Inpatient Physician Fee	10%	50% Coinsurance after deductible	No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge
Mental/Behavior Health Inpatient Facility Fee	10%	50% Coinsurance after deductible	$250 Copay per day (up to 5 days)	10% Coinsurance after deductible	50% Coinsurance after deductible	$500 Copay per admission
Substance Use Disorder Outpatient Office Visits	$15	50% Coinsurance after deductible	$15 Sharp: No Charge	$15	50% Coinsurance after deductible	$10
Substance Use Inpatient Physician Fee	10%	50% Coinsurance after deductible	No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge
Substance Use Inpatient Facility Fee (e.g. hospital room)	10%	50% Coinsurance after deductible	$250 per day (up to 5 days)	10% Coinsurance after deductible	50% Coinsurance after deductible	$500 Copay per admission
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Sharp, Blue Shield, Oscar: Pediatric Dental Embedded Kaiser: Not Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$4,500**	**Health Net: $9,000 Blue Shield : $9,000**	**$4,500**	**$3,800**	**$9,000**	**$3,000**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$9,000**	**Health Net: $18,000 Blue Shield: $18,000**	**$9,000**	**$7,600**	**$18,000**	**$6,000**

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Notes

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.

COVERED CALIFORNIA SMALL BUSINESS

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Gold (80%)	•Health Net 250/25 (PPO) •Blue Shield 250/25 (PPO) •Sharp 250/25 (Performance HMO)	•Health Net 250/25 (OON) •Blue Shield 250/25 (OON)	•Health Net 750/15 Alt (Value PPO)		Health Net 1000/30 Alt (EnhancedCare PPO)		Oscar 0/30 Alt (EPO)	Health Net 0/30 Alt (PPO)		•Kaiser 250/25 (HMO) •Blue Shield 250/25 (Trio HMO) •Sharp 250/25 (Premier HMO) Oscar 250/25 (EPO)	•Kaiser Gold 500/30 Alt (HMO)
Service Type	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**
Individual Deductible (if any)	$250	Health Net: $2,000 Blue Shield: $1,000	$750	$2,250	$1,000 /$250 Pharmacy	$2,000	$0	$0	$2,000	$250	$500
Family Deductible (if any)	$500	Health Net: $4,000 Blue Shield: $2,000	$1,500	$4,500	$2,000 /$500 Pharmacy	$4,000	$0	$0	$4,000	$500	$1,000
Preventive Care/Screening/ Immunization	No Charge	Health Net: 50% Coinsurance after deductible Blue Shield: 100%	No Charge	50% Coinsurance after deductible	No Charge	100%	No Charge	No Charge	50% Coinsurance after Deductible	No Charge	No Charge
Primary Care Visit to treat an injury, illness or condition	$25	50% Coinsurance after deductible	$15	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$30	$30	50% Coinsurance after Deductible	$25	$30
Other Practitioner Office Visit	$25	50% Coinsurance after deductible	$15	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$30	$30	50% Coinsurance after Deductible	$25	$30
Specialist Visit	$50	50% Coinsurance after deductible	$30 Copay after deductible	50% Coinsurance after deductible	$50	50% Coinsurance after deductible	$50	$50	50% Coinsurance after Deductible	$50	$35
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	50% Coinsurance after deductible	No Charge	50% Coinsurance after deductible	No Charge	No Charge	50% Coinsurance after Deductible	No Charge	No Charge
Urgent Care	$25	50% Coinsurance after deductible	$30 Copay after deductible	50% Coinsurance after deductible	$50	50% Coinsurance after deductible	$50	$50	50% Coinsurance after Deductible	$25	$30
Laboratory Tests	$25	50% Coinsurance after deductible	$25 Copay after deductible	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$50	$30	50% Coinsurance after Deductible	$25	$20
X-Rays and Diagnostic Imaging	$65	50% Coinsurance after deductible	$25 Copay after deductible	50% Coinsurance after deductible	$40	50% Coinsurance after deductible	$50	$40	50% Coinsurance after Deductible	$65	$40
Emergency Room Facility Fee (waived if admitted)	$250 after deductible	$250 after deductible	$250 Copay after deductible	$250 Copay after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	$350	30%	30%	$250 after deductible	$250 Copay after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge after deductible	No Charge after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	No Charge	30%	30%	No Charge	No Charge
Emergency Medical Transportation	$250 after deductible	$250 after deductible	$250 Copay after deductible	$250 Copay after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	$350	30%	30%	$250 after deductible	$250 Copay after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	20%	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	50% Coinsurance after Deductible	$300	$600 Copay after deductible
Outpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	30%	$40	No Charge
Outpatient Visit	20%	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$30	30%	50% Coinsurance after Deductible	20%	$35
Inpatient Physician/ Surgeon Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	50% Coinsurance after Deductible	No Charge	No Charge
Inpatient Facility Fee (e.g. hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	50% Coinsurance after Deductible	$600 / day (up to 5 days) after deductible	$600 / day (up to 5 days) after deductible.
Durable Medical Equipment	20%	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	100%	30%	30%	50% Coinsurance after Deductible	20%	20%
Imaging (CT/PET scans, MRIs)	20%	50% Coinsurance after deductible	$150 Copay after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$200	30%	50% Coinsurance after Deductible	$275	$300 Copay after deductible
Tier 1 (Generic Drugs)	$15	100%	$15	100%	$15	100%	$15	$15	100%	$15 Blue Shield: Level A $15, Level B $20	$15
Tier 2 (Preferred Brand Drugs)	$50	100%	$40 Copay after deductible	100%	$40 after pharmacy deductible	100%	$50	$40	100%	$50 Blue Shield: Level A $50, Level B $70	$50
Tier 3 (Nonpreferred Brand Drugs)	$80	100%	$70 Copay after deductible	100%	$70 after pharmacy deductible	100%	$75	$70	100%	$80 Kaiser: $50 Blue Shield: Level A $80, Level B $110	$50
Tier 4 (Specialty Drugs)	20% (up to $250 / script)	100%	30% Coinsurance after deductible (up to $250 / script)	100%	30% Coinsurance after pharmacy deductible (up to $250 / script)	100%	30% (up to $250)	30% (up to $250)	100%	20% (up to $250 / script)	20% (up to $250 / script)
Mental/Behavior Health Outpatient Office Visits	$25	50% Coinsurance after deductible	$15	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$30	$30	50% Coinsurance after Deductible	$25 Sharp: No Charge	$30
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	50% Coinsurance after Deductible	No Charge	No Charge
Mental/Behavior Health Inpatient Facility Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	50% Coinsurance after Deductible	$600 / day (up to 5 days) after deductible	$600 / day (up to 5 days) after deductible (up to $3,000 / admission)
Substance Use Disorder Outpatient Office Visits	$25	50% Coinsurance after deductible	$15	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$30	$30	50% Coinsurance after Deductible	$25 Sharp: No Charge	$30
Substance Use Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	50% Coinsurance after Deductible	No Charge	No Charge
Substance Use Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	30%	30%	50% Coinsurance after Deductible	$600 / day (up to 5 days) after deductible	$600 / day (up to 5 days) after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Blue Shield, Oscar: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$7,800**	**Health Net: $15,600 Blue Shield: $12,850**	**$7,600**	**$15,200**	**$7,400**	**$14,800**	**$6,000**	**$7,400**	**$14,800**	**$7,800**	**$7,000**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$15,600**	**Health Net: $31,200 Blue Shield: $25,700**	**$15,200**	**$30,400**	**$14,800**	**$29,600**	**$12,000**	**$14,800**	**$29,600**	**$15,600**	**$14,000**

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Notes

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2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.

COVERED CALIFORNIA SMALL BUSINESS

2020 Plan Summary

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Silver (70%)	•Health Net 2250/50 (PPO) •Blue Shield 2250/50 (PPO) •Sharp 2250/50 (Performance HMO) Oscar 2250/50 (EPO)	(OON) = Out of Network •Health Net 2250/50 (OON) •Blue Shield 2250/50 OON)	•Kaiser Silver 2250/50 (HMO) •Sharp 2250/50 (Premier HMO) •Blue Shield 2250/50 (Trio HMO)	(OON) = Out of Network •Health Net 2250/55 Alt (EnhancedCare PPO)		•Kaiser 1650/55 Alt (HMO)
Service Type	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Individual Deductible (if any)	$2,250 Medical/$300 Pharmacy	$4,500	$2,250 Medical/ $300 Pharmacy	$2,250 Medical/$300 Pharmacy	$4,500	$1,650 Medical/$350 Pharmacy
Family Deductible (if any)	$4,500 Medical/$600 Pharmacy	$9,000	$4,500 Medical/ $600 Pharmacy	$4,500 Medical/$600 Pharmacy	$9,000	$3,300 Medical/$700 Pharmacy
Preventive Care/Screening/Immunization	No Charge	100% Health Net: 50% Coinsurance after deductible	No Charge	No Charge	100%	No Charge
Primary Care Visit to treat an injury, illness or condition	$50	50% Coinsurance after deductible	$50	$55	50% Coinsurance after Deductible	$55
Other Practitioner Office Visit	$50	50% Coinsurance after deductible	$50	$55	50% Coinsurance after Deductible	$55
Specialist Visit	$85	50% Coinsurance after deductible	$85	$80	50% Coinsurance after Deductible	$80
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	50% Coinsurance after Deductible	No Charge
Urgent Care	$50	50% Coinsurance after deductible	$50	$80	50% Coinsurance after Deductible	$55
Laboratory Tests	$40	50% Coinsurance after deductible	$40	$40	50% Coinsurance after Deductible	$25
X-Rays and Diagnostic Imaging	$85	50% Coinsurance after deductible	$85	$65 Copay after deductible	50% Coinsurance after Deductible	$75 Copay after deductible
Emergency Room Facility Fee (waived if admitted)	$400 Copay after deductible	$400 Copay after deductible	$400 Copay after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	40% Coinsurance after deductible	40% Coinsurance after deductible	No Charge
Emergency Medical Transportation	$250 Copay after deductible	$250 Copay after deductible	$250 Copay after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	20%	50% Coinsurance after deductible	20%	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible	20%	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Outpatient Visit	20%	50% Coinsurance after deductible	20%	40% Coinsurance after deductible	50% Coinsurance after Deductible	$80
Inpatient Physician/Surgeon Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Kaiser: 20% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Durable Medical Equipment	20%	50% Coinsurance after deductible	20%	40% Coinsurance after deductible	100%	40%
Imaging (CT/PET scans, MRIs)	20%	50% Coinsurance after deductible	$300	40% Coinsurance after deductible	50% Coinsurance after Deductible	$350 Copay after deductible
Tier 1 (Generic Drugs)	$17 Copay after pharmacy deductible	100%	After pharmacy deductible: $17 Copay Blue Shield: Level A $17, Level B $22	$19	100%	$20
Tier 2 (Preferred Brand Drugs)	$65 Copay after pharmacy deductible	100%	After pharmacy deductible: $65 Copay Blue Shield: Level A $65, Level B $90	$65 Copay after pharmacy deductible	100%	$75 Copay after deductible
Tier 3 (Nonpreferred Brand Drugs)	$90 Copay after pharmacy deductible	100%	After pharmacy deductible: $90 Copay Kaiser: $65 copay Blue Shield: Level A $90 Level, B $130	$85 Copay after pharmacy deductible	100%	$75 Copay after deductible
Tier 4 (Specialty Drugs)	20% (up to $250 / script after pharmacy deductible)	100%	20% Coinsurance after deductible (up to $250 / script after pharmacy deductible)	40% Coinsurance after pharmacy deductible (up to $250)	100%	20% (up to $250 / script) after pharmacy deductible
Mental/Behavioral Health Outpatient Office Visits	$50 Blue Shield: $45	50% Coinsurance after deductible	$50	$55	50% Coinsurance after Deductible	$55
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Kaiser: 20% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	$50 Blue Shield: $45	50% Coinsurance after deductible	$50	$55	50% Coinsurance after Deductible	$55
Substance Use Disorder Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Kaiser: 20% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Substance Use Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after Deductible	40% Coinsurance after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Sharp, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Embedded	Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$7,800**	**Health Net: $15,600** **Blue Shield: $12,850**	**$7,800**	**$7,850**	**$15,600**	**$7,800**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$15,600**	**Health Net: $31,200** **Blue Shield: $25,700**	**$15,600**	**$15,600**	**$31,200**	**$15,600**

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2020 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Silver (70%)	(OON) = Out of Network •Health Net HDHP 1400/40% Alt (PPO) •Health Net HDHP 1400/40% Alt (EnhancedCare PPO)		•Kaiser HDHP 2500/20% (HMO) •Sharp Premier HDHP 2500/20% (HMO)	•Kaiser 1800/55 Alt (HMO)	Oscar 1500/50 Alt (EPO)	(OON) = Out of Network •Health Net 1700/50 Alt (Value PPO)	
Service Type	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Individual Deductible (if any)	$1,400	$2,800	$2,500 Self, $2,800 if enrolled as Family	$1,800 Medical/$350 Pharmacy	$1,500	$1,700	$3,400
Family Deductible (if any)	$2,800	$5,600	$5,000	$3,600 Medical/$700 Pharmacy	$3,000	$3,400	$6,800
Preventative Care/Screening/Immunization	No Charge	50% Coinsurance after deductible EnhancedCare: 100%	No Charge	No Charge	No Charge	No Charge	50% Coinsurance after deductible
Primary Care Visit to treat an injury, illness or condition	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55	$50	$50	50% Coinsurance after deductible
Other Practitioner Visit	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55	$50	$50	50% Coinsurance after deductible
Specialist Visit	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$75	$75	$75 Copay after deductible	50% Coinsurance after deductible
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge	50% Coinsurance after deductible
Urgent Care	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55	$75	$75 Copay after deductible	50% Coinsurance after deductible
Laboratory Tests	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$25 Copay after deductible	$75	$40 Copay after deductible	50% Coinsurance after deductible
X-Rays and Diagnostic Imaging	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55 Copay after deductible	$75	$50 Copay after deductible	50% Coinsurance after deductible
Emergency Room Facility Fee (waived if admitted)	40% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	$750	40% Coinsurance after deductible	40% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	40% Coinsurance after deductible	40% Coinsurance after deductible	Kaiser: 20% Coinsurance after deductible Sharp: No Charge after Deductible	No Charge	No Charge	40% Coinsurance after deductible	40% Coinsurance after deductible
Emergency Medical Transportation	40% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	$750	40% Coinsurance after deductible	40% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Visit	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$75	$50	40% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Facility Fee (e.g., hospital room)	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	40% Coinsurance after deductible	50% Coinsurance after deductible Enhanced: 100%	20% Coinsurance after deductible	45%	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$350 Copay after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Tier 1 (Generic Drugs)	$19 Copay after deductible	100%	20% Coinsurance after deductible (up to $250/script after medical deductible)	$20	$25	$19	100%
Tier 2 (Preferred Brand Drugs)	$65 Copay after deductible	100%	20% Coinsurance after deductible (up to $250/script after medical deductible)	$75 Copay after pharmacy deductible	$55	$65 Copay after deductible	100%
Tier 3 (Nonpreferred Brand Drugs)	$85 Copay after deductible	100%	20% Coinsurance after deductible (up to $250/script after medical deductible)	$75 Copay after pharmacy deductible	$125	40% Coinsurance after deductible (up to $250/script)	100%
Tier 4 (Specialty Drugs)	40% Coinsurance after deductible (up to $250/script)	100%	20% Coinsurance after deductible (up to $250/script after medical deductible)	20% Coinsurance after pharmacy deductible (up to $250/script	50% Coinsurance after deductible (up to $250/script)	40% Coinsurance after deductible (up to $250/script)	100%
Mental/Behavioral Health Outpatient Office Visits	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55	$50	$50	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Physician Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	40% Coinsurance after deductible	50% Coinsurance after deductible	Kaiser: 20% Coinsurance after deductible Sharp: No Charge	$55	$50	$50	50% Coinsurance after deductible
Substance Use Disorder Inpatient Physician Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Inpatient Facility Fee (e.g., hospital room)	40% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Embedded Pediatric Dental	Embedded	Embedded	Sharp: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded	Embedded	Embedded	Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$6,850**	**$13,700**	**$6,850**	**$7,800**	**$8,150**	**$7,800**	**$15,600**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$13,700**	**$27,400**	**$13,700**	**$15,600**	**$16,300**	**$15,600**	**$31,200**

Please Note: **This document is a high level benefit overview and is not intended as a substitution for the Evidence of Coverage (EOC) which can be viewed online at www.coveredca.com or requested from the Covered California for Small Business Customer Service Center at 855-777-6782.**

Notes

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.

COVERED CALIFORNIA SMALL BUSINESS

2020 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Bronze (60%)	•Health Net 6300/65 (PPO) •Blue Shield 6300/65 (PPO) •Sharp 6300/65 (Performance HMO)	(OON) = Out of Network •Health Net 6300/65 (OON) •Blue Shield 6300/65 (OON)	•Kaiser 6300/65 (HMO)	•Kaiser HDHP 6900/0% (HMO) •Sharp HDHP 6900/0% (Premier HMO) Oscar HDHP 6900/0% (EPO)	(OON) = Out of Network •Health Net HDHP 5600/20% Alt (PPO) •Health Net HDHP 5600/20% Alt (EnhancedCare PPO)	
Service Type	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Individual Deductible (if any)	$6,300 Medical/ $500 Pharmacy	Health Net: $12,600 Medical Blue Shield: $6,300 Medical	$6,300 Medical/ $500 Pharmacy	$6,900	$5,600	$11,200
Family Deductible (if any)	$12,600 Medical/ $1,000 Pharmacy	Health Net: $25,200 Medical Blue Shield: $12,600 Medical	$12,600 Medical/ $1,000 Pharmacy	$13,800	$11,200	$22,400
Preventive Care/Screening/ Immunization	No Charge	100% Health Net: 50% Coinsurance after deductible	No Charge	No Charge	No Charge	50% Coinsurance after deductible EnhancedCare: 100%
Primary care visit to treat an injury, illness or condition	$65 Copay with deductible*	50% Coinsurance after deductible	$65 Copay with deductible*	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Other Practitioner Office Visit	$65 Copay with deductible*	50% Coinsurance after deductible	$65 Copay with deductible*	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Specialist visit	$95 Copay after deductible*	50% Coinsurance after deductible	$95 Copay after deductible*	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	No Charge	50% Coinsurance after deductible
Urgent Care	$65 Copay after deductible*	50% Coinsurance after deductible	$65 Copay after deductible*	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Laboratory Tests	$40	50% Coinsurance after deductible	$40	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
X-Rays and Diagnostic Imaging	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Emergency Room Facility Fee (waived if admitted)	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Emergency Medical Transportation	40% Coinsurance after deductible	40% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Physician/Surgeon Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Visit	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Facility Fee (e.g. hospital room)	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	40% Coinsurance after deductible	100% Health Net: 50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible EnhancedCare: 100%
Imaging (CT/PET scans, MRIs)	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Tier 1 (Generic Drugs)	$18 after pharmacy deductible	100%	$18 after pharmacy deductible	0% Coinsurance after deductible	$5 Copay after deductible	100%
Tier 2 (Preferred Brand Drugs)	40% up to $500 per script after pharmacy deductible	100%	40% up to $500 per script after pharmacy deductible	0% Coinsurance after deductible	$15 Copay after deductible	100%
Tier 3 (Nonpreferred Brand Drugs)	40% up to $500 per script after pharmacy deductible	100%	40% up to $500 per script after pharmacy deductible	0% Coinsurance after deductible	$40 Copay after deductible	100%
Tier 4 (Specialty Drugs)	40% up to $500 per script after pharmacy deductible	100%	40% up to $500 per script after pharmacy deductible	0% Coinsurance after deductible	20% Coinsurance after deductible (up to $500)	100%
Mental/Behavior Health Outpatient office visits	Health Net: $65 Blue Shield, Sharp: $65 with deductible*	50% Coinsurance after deductible	$65 Copay with deductible*	0% Coinsurance after deductible Sharp: No charge after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient physician fee	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility fee	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Outpatient office visits	Health Net: $65 Blue Shield, Sharp: $65 with deductible*	50% Coinsurance after deductible	$65 Copay with deductible*	0% Coinsurance after deductible Sharp: No charge after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Inpatient Physician Fee	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Inpatient Facility Fee (e.g. hospital room)	40% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Not Embedded	Sharp, Oscar: Embedded Kaiser: Not Embedded	Embedded	Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$7,800**	**Health Net: $15,600** **Blue Shield: $12,850**	**$7,800**	**$6,900**	**$6,850**	**$13,700**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$15,600**	**Health Net: $31,200** **Blue Shield: $25,700**	**$15,600**	**$13,800**	**$13,700**	**$27,400**

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*** Deductible waived first three non-preventive visits**

Notes

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In network services include services provided by an out-of-network provider but are approved as in-network by the issuer.

2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.

3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.

4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.

After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.

5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.