2017 Standard Benefits
Covered California for Small Business

	Platinum (90%)			
	Platinum 90 Coinsurance Plans:	Platinum 90 Coinsurance (Out of Network)	Platinum 90 Copay Plans:	
Service Type	Platinum 90 Coinsurance 0/15: •Health Net •Blue Shield (2017 New Plan) •Sharp Network 2	Platinum 90 Coinsurance 0/15 (out of Network): •Health Net •Blue Shield (2017 New Plan)	Platinum 90 Copay 0/15: •Kaiser •Western Health Advantage •CCHP •Blue Shield •Sharp Network 1	•Kaiser Platinum 90 HMO 0/10 Alternative
Individual Deductible (if any)	$0	$1,000 Blue Shield: $0	$0	$0 Medical/ $0 Pharmacy
Family Deductible (if any)	$0	$2,000 Blue Shield: $0	$0	$0 Medical/ $0 pharmacy
Preventative Care/ Screening/Immunization	No Charge	100%	No Charge	No Charge
Primary Care Visit to treat an injury, illness, or Condition	$15	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$10
Specialist Visit	$40	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$40	$20
Prenatal Care and Preconception Visit	No Charge	Health Net: 50% Coinsurance after deductible Blue Shield 50%	No Charge	No Charge
Urgent Care	$15	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$10
Laboratory Tests	$20	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$20	$20
X-Ray and Diagnostic Imaging	$40	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$40	$40
Emergency Room Facility Fee (waived if admitted)	$150	$150	$150	$200
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge
Emergency medical transportation	$150	$150	$150	$150
Outpatient Surgery Facility Fee (e.g.,ASC)	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$250	$250
Outpatient Physician/Surgeon Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$40	$40
Inpatient Physician/Surgeon Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$40 Kaiser: $40 per day (up to 5 days)	No Charge
Inpatient Facility Fee (e.g. hospital room)	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$250 per day (up to 5 days)	$500 per admission
Durable Medical Equipment	10%	Health Net: 100% Blue Shield: 50%	10%	10%
Imaging (CT/PET scans, MRIs)	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$150	$150
Tier 1 (Generic Drugs)	$5	100%	$5	$5
Tier 2 (Preferred Brand Drugs)	$15	100%	$15	$15
Tier 3 (Nonpreferred Brand Drugs)	$25	100%	$25 Kaiser:$15	$15
Tier 4 (Specialty Drugs)	10% (up to $250 per script)	100%	10% (up to $250 per script)	10% (up to $250 per script)
Mental/Behavior Health Outpatient Office Visits	$15 Health Net: No Charge	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$10
Mental/Behavior Health Inpatient Physician Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$250 per day (up to 5 days)	$500 per admission
Substance Use Disorder Outpatient Office Visits	$15 Health Net: No Charge	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$10
Substance Use Inpatient Facility Fee (e.g. hospital room	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$250 per day (up to 5 days)	$500 per admission
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Sharp, Western Health Advantage, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded
Acupuncture	$15	100% Blue Shield: 50%	$15 Note: Kaiser***	$10
Chiropractic Care	Not Covered	Not Covered	Kaiser, CCHP, Blue Shield, Sharp: Not Covered Western Health Advantage: $15	Not Covered
INDIVIDUAL OUT-OF-POCKET MAXIMUM	$4,000	Health Net: $9,000 Blue Shield : $8,000	$4,000	$4,000
FAMILY OUT-OF-POCKET MAXIMUM	$8,000	Health Net: $18,000 Blue Shield: $16,000	$8,000	$8,000

Please note: this document is a high level benefit overview and is not intended as a substitution for the Summary of Benefits and Coverage (SBC) which can be viewed online at www.coveredca.com or requested from the Covered California for Small Business Customer Service Center at 877-453-9198.

* Deductible applies after 1st three non-preventitive vists
**Up to $500 per script after pharmacy deductible
*** Physician referred

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 carrier.
2) For covered out of network services in a PPO plan, these Standard 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 linked to HSA plans, 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 carrier pays all costs for covered services for all family members.
5) For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2600 for Plan Year 2016. 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.

2017 Standard Benefits
Covered California for Small Business

Service Type	Gold (80%)				
	Gold 80 Coinsurance Plans:	Gold 80 Coinsurance Out of Network	Gold 80 Copay Plans:		
	Gold 80 Coinsurance 0/30: •Health Net •Blue Shield (2017 New Plan) •Sharp Network 2	• Gold 80 Coinsurance 0/30 (Out of Network): •Health Net •Blue Shield (2017 New Plan)	Gold 80 Copay 0/30: •Kaiser •Western Health Advantage •CCHP •Blue Shield •Sharp Network 1	•Kaiser Gold 80 HMO 500/35 Alternate	•Health Net Gold 80 EPO 1400/15 Alternate
Individual Deductible (if any)	$0	Health Net: $2000 Blue Shield: $0	$0	$500	$1,400 Medical/ $250 Pharmacy
Family Deductible (if any)	$0	Health Net: $4,000 Blue Shield: $0	$0	$1,000	$2,800 Medical/ $500 Pharmacy
Preventative Care/Screening/ Immunization	No Charge	100%	No Charge	No Charge	No Charge
Primary Care Visit to treat an injury, illness or condition	$30	50% Coinsurance after deductible Blue Shield : 50%	$30	$35	$15
Specialist Visit	$55	50% Coinsurance after deductible Blue Shield : 50%	$55	$35	$45
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible Blue Shield : 50%	No Charge	No Charge	No Charge
Urgent Care	$30	50% Coinsurance after deductible Blue Shield : 50%	$30	$35	$45
Laboratory Tests	$35	50% Coinsurance after deductible Blue Shield : 50%	$35	$20	$20 Copay after deductible
X-Rays and Diagnostic Imaging	$55	50% Coinsurance after deductible Blue Shield : 50%	$55	$40	$30 Copay after deductible
Emergency Room Facility Fee (waived if admitted)	$325	$325	$325	$250 Copay after deductible	$200
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge	No Charge
Emergency Medical Transportation	$250	$250	$250	$250 Copay after deductible	$200
Outpatient Surgery Facility Fee (e.g., ASC)	20%	50% Coinsurance after deductible Blue Shield : 50%	$600	$600 Copay after deductible	20% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible Blue Shield : 50%	$55	$55 Copay after deductible	20% Coinsurance after deductible
Inpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible Blue Shield : 50%	$55	No Charge	20% Coinsurance after deductible
Inpatient Facility Fee (e.g. hospital room)	20%	50% Coinsurance after deductible Blue Shield : 50%	$600 per day (up to 5 days)	$600 per day (up to 5 days) after deductible	20% Coinsurance after deductible
Durable Medical Equipment	20%	100% Blue Shield: 50%	20%	20%	20% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	20%	50% Coinsurance after deductible Blue Shield : 50%	$275	$250	20% Coinsurance after deductible
Tier 1 (Generic Drugs)	$15	100%	$15	$15	$5
Tier 2 (Preferred Brand Drugs)	$55	100%	$55	$50	$15 Copay after deductible
Tier 3 (Nonpreferred Brand Drugs)	$75	100%	$75 Kaiser: $55	$50	20% Coinsurance after deductible
Tier 4 (Specialty Drugs)	20% (up to $250 per script)	100%	20% (up to $250 per script)	20% (up to $250 per script	20% Coinsurance after deductible
Mental/Behavior Health Outpatient Office Visits	$30 Health Net: No Charge	50% Coinsurance after deductible Blue Shield : 50%	$30	$35	$15
Mental/Behavior Health Inpatient Physician Fee	20%	50% Coinsurance after deductible Blue Shield : 50%	$600 per day (up to 5 days)	$600 per day (up to 5 days) after deductible	20% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	$30 Health Net: No Charge	50% Coinsurance after deductible Blue Shield : 50%	$30	$35	$15
Substance Use Inpatient Facility Fee (e.g., hospital room)	20%	50% Coinsurance after deductible Blue Shield : 50%	$600 per day (up to 5 days)	$600 per day (up to 5 days) after deductible	20% Coinsurance after deductible
Embedded Pediatric Dental	Health Net:, Blue Shield: Pediatric Dental Embedded	Pediatric Dental Embedded	Western Health Advantage, CCHP, Blue Shield: Pediatric Dental Embedded. Kaiser: Not Embedded	Not Embedded	Pediatric Dental Embedded
Acupuncture	$30	100% Blue Shield: 50%	$30 Note: Kaiser ***	$35	$15
Chiropractic Care	Not Covered	Not Covered	Kaiser, CCHP, Blue Shield, Sharp: Not Covered Western Health Advantage: $15	Not Covered	Not Covered
MAXIMUM OUT-OF-POCKET FOR ONE	$6,750	$13, 500 Blue Shield: $10,000	$6, 750	$6,750	$6,000
MAXIMUM OUT-OF-POCKET FOR FAMILY	$13,500	$27,000 Blue Shield: $20,000	$13,500	$13, 500	$12,000

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* Deductible applies after 1st three non-preventitive visits
**Up to $500 per script after pharmacy deductible
***Physician referred

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 carrier.
2) For covered out of network services in a PPO plan, these Standard 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 linked to HSA plans, 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 carrier pays all costs for covered services for all family members.
5) For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2600 for Plan Year 2016. 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.

2017 Standard Benefits
Covered California for Small Business

	Silver (70%)					
	Silver 70 Coinsurance Plans:	Silver 70 Coinsurance Out of Network	Silver 70 Copay Plans:			Silver 70 HSA Plans:
Service Type	Silver 70 Coinsurance 2000/45: •Health Net •Blue Shield (2017 New Plan) •Sharp Network 2	•Silver70 Coinsurance 2000/45 (Out of Network: •Health Net •Blue Shield (2017 New plan)	Silver 70 Copay 2000/45: •Kaiser •Western Health Advantage •CCHP •Sharp Network 1 •Blue Shield	•Kaiser Silver 70 HMO 1000/50 Alternate	Silver 70HDHP 2000/20%: •Kaiser (2017 New Plan) •Western Health Advantage •Sharp Network 1	•Health Net Silver 70 EPO 1900/20 Alternate
Individual Deductible (if any)	$2,000 Medical/ $250 Pharmacy/ $0 Dental	$4000 Medical	$2,000 Medical/ $250 Pharmacy/ $0 Dental	$1,000 Medical/ $200 Pharmacy	$2000 Integrated	$1,900 Medical/ $250 Pharmacy
Family Deductible (if any)	$4,000 Medical/ $500 Pharmacy/ $0 Dental	$8000 Medical	$4,000 Medical/ $500 Pharmacy/ $0 Dental	$2,000 Medical/ $400 Pharmacy	$4000 Integrated	$3,800 Medical/ $500 Pharmacy
Preventative Care/Screening/Immunization	No Charge	100%	No Charge	No Charge	No Charge	No Charge
Primary Care Visit to treat an injury, illness or condition	$45	50% Coinsurance after deductible	$45	$50	20% Coinsurance after deductible	$20
Specialist Visit	$75	50% Coinsurance after deductible	$75	$50	20% Coinsurance after deductible	$60
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge
Urgent Care	$45	50% Coinsurance after deductible	$45	$50	20% Coinsurance after deductible	$60
Laboratory Tests	$40	50% Coinsurance after deductible	$40	$50	20% Coinsurance after deductible	$50 Copay after deductible
X-Rays and Diagnostic Imaging	$70	50% Coinsurance after deductible	$70	$50	20% Coinsurance after deductible	$60 Copay after deductible
Emergency Room Facility Fee (waived if admitted)	$350	$350	$350	30% Coinsurance after deductible	20% Coinsurance after deductible	$300
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge	0% Coinsurance after deductible	No Charge
Emergency Medical Transportation	$250 Copay after deductible	$250 Copay after deductible	$250 Copay after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	$300
Outpatient Surgery Facility Fee (e.g., ASC)	20%	50% Coinsurance after deductible	20%	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible	20%	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	No Charge	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	20%	100% Blue Shield: 50% Coinsurance after deductible	20%	30%	20% Coinsurance after deductible	50% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	20%	50% Coinsurance after deductible	$300	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Tier 1 (Generic Drugs)	$15	100%	$15	$25	20% (up to $250 per script after pharmacy deductible)	$10
Tier 2 (Preferred Brand Drugs)	$55 Copay after pharmacy deductible	100%	$55 Copay after pharmacy deductible	$50 Copay after deductible	20% (up to $250 per script after pharmacy deductible)	$55 Copay after deductible
Tier 3 (Nonpreferred Brand Drugs)	$85 Copay after pharmacy deductible	100%	$85 (up to $250 per script after pharmacy deductible)	$50 Copay after deductible	20% (up to $250 per script after pharmacy deductible)	50% Coinsurance after deductible
Tier 4 (Specialty Drugs)	20% (up to $250 per script after pharmacy deductible)	100%	20% (up to $250 per script after phamacy deductible)	20% (up to $250 per script) after pharmacy deductible	20% (up to $250 per script after pharmacy deductible)	50% Coinsurance after deductible
Mental/Behavioral Health Outpatient Office Visits	$45 Health Net: No Charge	50% Coinsurance after deductible	$45	$50	20% Coinsurance after deductible	$20
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	$45 Health Net: No Charge	50% Coinsurance after deductible	$45	$50	20% Coinsurance after deductible	$20
Substance Use Disorder Inpatient Physician Fee (e.g. hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Western Health Advantage, CCHP, Sharp, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded	Western Health Advantage, Sharp: Pediatric Dental Embedded Kaiser: Not Embedded	Pediatric Dental Embedded
Acupuncture	$45	100% Blue Shield: 50% Coinsurance after deductible	45 Note Kaiser ***	$50 *** (20 visits per year combined with Acupuncture)	20% Coinsurance after deductible ***	$20
Chiropractic Care	Not Covered	Not Covered	Kaiser, CCHP, Sharp: Not Covered Western Health Advantage: $15	$15 (20 visits per year combined with Acupuncture)	Not Covered	Not Covered
MAXIMUM OUT-OF-POCKET FOR ONE	$6,800	$13, 600 Blue Shield: $10,000	$6,800	$6,750	$6,550	$6,800
MAXIMUM OUT-OF-POCKET FOR FAMILY	$13,600	$27, 200 Blue shield: $20,000	$13,600	$13,500	$13,100	$13,600

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* Deductible applies after 1st three non-preventitive visits
**Up to $500 per script after pharmacy deductible
*** Physician Referred

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 carrier.
2) For covered out of network services in a PPO plan, these Standard 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 linked to HSA plans, 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 carrier pays all costs for covered services for all family members.
5) For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2600 for Plan Year 2016. 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.

FOR SMALL BUSINESS

2017 Standard Benefits
Covered California for Small Business

Service Type	Bronze (60%)				
	Bronze 60 Coinsurance Plans:	Bronze 60 Coinsurance (Out of Network):	Bronze 60 Copay Plans:	Bronze 60 HDHP Plans:	
	Bronze 60 Coinsurance 6300/75: •Health Net •Blue Shield •Sharp Network 2	Bronze 60 Coinsurance 6300/75 (Out of Network): •Health Net •Blue Shield	Bronze 60 Copay 6300/75: •Kaiser •Western Health Advantage •CCHP	Bronze 60 HDHP 4800/40%: •Kaiser •Western Health Advantage •Sharp Network 1	•Western Health Advantage Bronze 60 HDHP HMO 6500/0 Alternate
Individual Deductible (if any)	$6,300 Medical/ $500 Pharmacy/ $0 Dental	$12,600 Medical Blue Shield: $6,300 Medical	$6,300 Medical/ $500 Pharmacy/ $0 Dental	$4,800 Integrated	$6,500
Family Deductible (if any)	$12,600 Medical/ $1,000 Pharmacy/ $0 Dental	$25,200 Medical Blue Shield: $12,600 Medical	$12,600 Medical/ $1,000 Pharmacy/$0 Dental	$9,600 Integrated	$13,000
Preventative Care/Screening/ Immunization	No Charge	100%	No Charge	No Charge	0% Coinsurance
Primary care visit to treat an injury, illness or condition	$75*	50% Coinsurance after deductible	$75*	40% Coinsurance after deductible	0% Coinsurance after deductible
Specialist visit	$105*	50% Coinsurance after deductible	$105*	40% Coinsurance after deductible	0% Coinsurance after deductible
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	0% Coinsurance
Urgent Care	$75*	50% Coinsurance after deductible	$75*	40% Coinsurance after deductible	0% Coinsurance after deductible
Laboratory Tests	$40	50% Coinsurance after deductible	$40	40% Coinsurance after deductible	0% Coinsurance after deductible
X-Rays and Diagnostic Imaging	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Emergency Room Facility Fee (waived if admitted)	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	0% Coinsurance after deductible	0% Coinsurance
Emergency Medical Transportation	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Outpatient Physician/Surgeon Fee	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Inpatient Facility Fee (e.g. hospital room)	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Durable Medical Equipment	100% Coinsurance after deductible	100%	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Tier 1 (Generic Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance (up to $500 per script after pharmacy deductible)	0% Coinsurance after deductible
Tier 2 (Preferred Brand Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance (up to $500 per script after pharmacy deductible)	0% Coinsurance after deductible
Tier 3 (Nonpreferred Brand Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance (up to $500 per script after pharmacy deductible)	0% Coinsurance after deductible
Tier 4 (Specialty Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance (up to $500 per script after pharmacy deductible)	0% Coinsurance after deductible
Mental/Behavior Health Outpatient office visits	$75* Health Net: No Charge	50% Coinsurance after deductible	$75*	40% Coinsurance after deductible	0% Coinsurance after deductible
Mental/Behavior Health Inpatient physician fee	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Substance Use Disorder Outpatient office visits	$75* Health Net: No Charge	50% Coinsurance after deductible	$75*	40% Coinsurance after deductible	0% Coinsurance after deductible
Substance Use inpatient facility fee (e.g. hospital room	100% Coinsurance after deductible	100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Embedded Pediatric Dental	Health Net: Pediatric Dental Embedded	Pediatric Dental Embedded	Western Health Advantage, CCHP: Pediatric Dental Embedded Kaiser: Not Embedded	Western Health Advantage: Pediatric Dental Embedded Kaiser: Not Embedded	Pediatric Dental Embedded
Acupuncture	$75*	100% Blue Shield: 50% Coinsurance after deductible	Kaiser ***, Western Health Advantage, CCHP: $75*	40% Coinsurance after deductible ***	0% Coinsurance after deductible
Chiropractic Care	Not Covered	Not Covered	Kaiser, CCHP: Not Covered Western Health Advantage : $15	Not Covered	Not Covered
MAXIMUM OUT-OF-POCKET FOR ONE	$6,800	$13,600 Blue Shield: $10,000	$6,800	$6,550	$6,500
MAXIMUM OUT-OF-POCKET FOR FAMILY	$13,600	$27,200 Blue Shield: $20,000	$13,600	$13,100	$13,000

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* Deductible waived first three visits
**Up to $500 per script after pharmacy deductible
*** Physician referred

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 carrier.
2) For covered out of network services in a PPO plan, these Standard 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 linked to HSA plans, 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 carrier pays all costs for covered services for all family members.
5) For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2600 for Plan Year 2016. 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.