COVERED CALIFORNIA | FOR SMALL BUSINESS

2018 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 Copay 0/15 (HMO) •CCHP Copay 0/15 (HMO) •Blue Shield Copay 0/15 (Trio HMO) •Sharp Copay 0/15 (Premier HMO)	•Kaiser 0/10 Alt (HMO)
Service Type	In-Network	Out-of- Network	In-Network	In-Network
Individual Deductible (if any)	$0	Health Net: $1,000 Blue Shield: $0	$0	$0
Family Deductible (if any)	$0	Health Net: $2,000 Blue Shield: $0	$0	$0
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	$30	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$30	$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	$15	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$20
X-Ray and Diagnostic Imaging	$30	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$30	$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%	$100	$300
Outpatient Physician/Surgeon Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$25	No Charge
Inpatient Physician/Surgeon Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	No Charge	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%	$75	$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: 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%	No Charge	No Charge
Mental/Behavior Health Inpatient Facility Fee	10%	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 Physician Fee	10%	50%	No Charge	No Charge
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, Sharpe, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	$3,350	Health Net: $9,000 Blue Shield : $8,000	$3,350	$3,000
MAXIMUM OUT-OF-POCKET FOR FAMILY	$6,700	Health Net: $18,000 Blue Shield: $16,000	$6,700	$6,000

✓ *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.

* Deductible applies after 1st three non-preventative visits

** Up to $500 per script after pharmacy deductible

*** Blue Card Program available for Out-of-State employee coverage

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. Services provided by an out-of-network provider but are approved as in-network by the carrier are considered in-network.

2) For covered out of network services in a PPO plan, the Patient Centered 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 carrier'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 $2,700 for Plan Year 2018. 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 | FOR SMALL BUSINESS

2018 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Gold (80%)	•Health Net 80 0/25 (PPO) •Blue Shield 80 0/25 (PPO) •Sharp 80 0/25 (Performance HMO)	(OON) = Out of Network •Health Net 0/25 (OON) •Blue Shield 0/25 (OON)	(OON) = Out of Network •Health Net 750/10 Alt (Value PPO) - *NEW 2018*		•Kaiser 80 0/25 (HMO) •CCHP 80 0/25 (HMO) •Blue Shield 80 0/25 (Trio HMO) •Sharp 80 0/25 (Premier HMO)	•Kaiser Gold 80 500/30 Alt (HMO)
Service Type	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	In-Network
Individual Deductible (if any)	$0	Health Net: $2000 Blue Shield: $0	$750	$2,250	$0	$500
Family Deductible (if any)	$0	Health Net: $4,000 Blue Shield: $0	$1,500	$4,500	$0	$1,000
Preventative Care/Screening/ Immunization	No Charge	100%	No Charge	100%	No Charge	No Charge
Primary Care Visit to treat an injury, illness or condition	$25	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$10	50% coinsurance after deductible	$25	$30
Specialist Visit	$55	Health Net:50% Coinsurance after deductible Blue Shield : 50%	$30 after deductible	50% coinsurance after deductible	$55	$35
Prenatal Care and Preconception Visit	No Charge	Health Net:50% Coinsurance after deductible Blue Shield : 50%	No Charge	50% coinsurance after deductible	No Charge	No Charge
Urgent Care	$25	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$30 after deductible	50% coinsurance after deductible	$25	$30
Laboratory Tests	$35	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$20 after deductible	50% coinsurance after deductible	$35	$20
X-Rays and Diagnostic Imaging	$55	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$20 after deductible	50% coinsurance after deductible	$55	$40
Emergency Room Facility Fee (waived if admitted)	$325	$325	$250 after deductible	$250 after deductible	$325	$250 Copay after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	100%	No Charge	No Charge
Emergency Medical Transportation	$250	$250	$250 after deductible	$250 after deductible	$250	$250 Copay after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30% after deductible	50% coinsurance after deductible	$300	$600 Copay after deductible
Outpatient Physician/ Surgeon Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	20% after deductible	50% coinsurance after deductible	$40	No Charge
Inpatient Physician/ Surgeon Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30%	50% coinsurance after deductible	No Charge	No Charge
Inpatient Facility Fee (e.g. hospital room)	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30%	50% coinsurance after deductible	$600 / day (up to 5 days)	$600 / day (up to 5 days) after deductible
Durable Medical Equipment	20%	Health Net:100% Blue Shield: 50%	30%	100%	20%	20%
Imaging (CT/PET scans, MRIs)	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$150 after deductible	50% coinsurance after deductible	$275	$300 after deductible
Tier 1 (Generic Drugs)	$15	100%	$10	100%	$15	$15
Tier 2 (Preferred Brand Drugs)	$55	100%	$25 after deductible	100%	$55	$50
Tier 3 (Nonpreferred Brand Drugs)	$75	100%	$50 after deductible	100%	$75 Kaiser: $55	$50
Tier 4 (Specialty Drugs)	20% (up to $250 / script)	100%	30% (up to $250 / script)	100%	20% (up to $250 / script)	20% (up to $250 / script)
Mental/Behavior Health Outpatient Office Visits	$25	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$10	50% Coinsurance after deductible	$25	$30
Mental/Behavior Health Inpatient Physician Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30% after deductible	50% Coinsurance after deductible	No Charge	No Charge
Mental/Behavior Health Inpatient Facility Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30%	50% Coinsurance after deductible	$600 / day (up to 5 days)	$600 / day (up to $3,000 / admission)
Substance Use Disorder Outpatient Office Visits	$25	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$10	50% Coinsurance after deductible	$25	$30
Substance Use Inpatient Physician Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30%	50% Coinsurance after deductible	No Charge	No Charge
Substance Use Inpatient Facility Fee (e.g., hospital room)	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30% after deductible	50% Coinsurance after deductible	$600 / day (up to 5 days)	$600 / day (up to 5 days) after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	$6,000	Health Net: $13, 500 Blue Shield: $10,000	$7,150	$14,300	$6,000	$7,000
MAXIMUM OUT-OF-POCKET FOR FAMILY	$12,000	Health Net: $27,000 Blue Shield: $20,000	$14,300	$28,600	$12,000	$14,000

✓ *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.

* Deductible applies after 1st three non-preventative 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. Services provided by an out-of-network provider but are approved as in-network by the carrier are considered in-network.
2) For covered out of network services in a PPO plan, the Patient Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable carrier's 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 carrier'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 $2,700 for Plan Year 2018. 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 | FOR SMALL BUSINESS

2018 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Silver (70%)	•Health Net 70 2000/45 (PPO) •Blue Shield 70 2000/45 (PPO) •Sharp 70 2000/45 (Performance HMO)	(OON) = Out of Network •Health Net 70 2000/45 (OON) •Blue Shield 70 2000/45 (OON)	•Kaiser Silver 2000/45 (HMO) •CCHP Silver 2000/45 (HMO) •Sharp 2000/45 (Premier HMO) •Blue Shield 2000/45 (Trio HMO)	•Kaiser 70 1000/50 Alt (HMO)
Service Type	In-Network	Out-of-Network	In-Network	In-Network
Individual Deductible (if any)	$2,000 Medical/ $125 Pharmacy	$4,000 Medical	$2,000 Medical/ $125 Pharmacy	$1,000 Medical/ $250 Pharmacy
Family Deductible (if any)	$4,000 Medical/ $250 Pharmacy	$8,000 Medical	$4,000 Medical/ $250 Pharmacy	$2,000 Medical/ $500 Pharmacy
Preventative Care/Screening/Immunization	No Charge	100%	No Charge	No Charge
Primary Care Visit to treat an injury, illness or condition	$45	50% Coinsurance after deductible	$45	$50
Specialist Visit	$75	50% Coinsurance after deductible	$75	$70
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge
Urgent Care	$45	50% Coinsurance after deductible	$45	$50
Laboratory Tests	$40	50% Coinsurance after deductible	$40	$50
X-Rays and Diagnostic Imaging	$70	50% Coinsurance after deductible	$70	$65
Emergency Room Facility Fee (waived if admitted)	$350	$350	$350	35% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge
Emergency Medical Transportation	$250 Copay after deductible	$250 Copay after deductible	$250 Copay after deductible	35% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	20%	50% Coinsurance after deductible	20%	35% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible	20%	35% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible
Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible
Durable Medical Equipment	20%	Health Net: 100% Blue Shield: 50% Coinsurance after deductible	20%	35%
Imaging (CT/PET scans, MRIs)	20%	50% Coinsurance after deductible	$300	$350 after deductible
Tier 1 (Generic Drugs)	$15 Copay after pharmacy deductible	100%	$15 Copay after pharmacy deductible	$25
Tier 2 (Preferred Brand Drugs)	$55 Copay after pharmacy deductible	100%	$55 Copay after pharmacy deductible	$70 Copay after deductible
Tier 3 (Nonpreferred Brand Drugs)	$85 Copay after pharmacy deductible	100%	$85 Kaiser: $55 (up to $250/script after pharmacy deductible)	$70 Copay after deductible
Tier 4 (Specialty Drugs)	20% (up to $250 / script after pharmacy deductible)	100%	20% (up to $250 / script after pharmacy deductible)	20% (up to $250 / script) after pharmacy deductible
Mental/Behavioral Health Outpatient Office Visits	$45 Health Net: No Charge	50% Coinsurance after deductible	$45	$50
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility Fee	20%	50% Coinsurance after deductible	20%	35% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	$45 Health Net: No Charge	50% Coinsurance after deductible	$45	$50
Substance Use Disorder Inpatient Physician Fee	20%	50% Coinsurance after deductible	20%	No Charge
Substance Use Disorder Inpatient Facility Fee (e.g. hospital room)	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	35% Coinsurance after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Sharp, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	$7,000	Health Net: $13, 600 Blue Shield: $10,000	$7,000	$7,000
MAXIMUM OUT-OF-POCKET FOR FAMILY	$14,000	Health Net: $27, 200 Blue Shield: $20,000	$14,000	$14,000

✓ *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.

* Deductible applies after 1st three non-preventative 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. Services provided by an out-of-network provider but are approved as in-network by the carrier are considered in-network.
2) For covered out of network services in a PPO plan, the Patient Centered Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable carrier's 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 carrier'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 $2,700 for Plan Year 2018. 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.

2018 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Silver (70%)	•Kaiser 70 HDHP 2000/20% (HMO) •Sharp Premier 70 HDHP 2000/20% (HMO)	(OON) = Out of Network •Health Net HDHP 1350/40 Alt (PPO) - *NEW 2018* •Health Net HDHP 1350/40 Alt (EnhancedCare PPO)- *NEW 2018*		(OON) = Out of Network •Health Net 1700/30 Alt (Value PPO) - *NEW 2018*	
Service Type	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible (if any)	$2,000 Integrated ($2,700 if enrolled with family coverage)	$1,350	$2,700	$1,700	$3,400
Family Deductible (if any)	$4,000 Integrated	$2,700	$5,400	$3,400	$6,800
Preventative Care/Screening/Immunization	No Charge (deductible waived)	No Charge	100%	No Charge	100%
Primary Care Visit to treat an injury, illness or condition	20% Coinsurance after deductible	$40 Copay after deductible	50% Coinsurance after deductible	$30	50% Coinsurance after deductible
Specialist Visit	20% Coinsurance after deductible	$60 Copay after deductible	50% Coinsurance after deductible	$75 after deductible	50% Coinsurance after deductible
Prenatal Care and Preconception Visit	No Charge (deductible waived)	No Charge	50% Coinsurance after deductible	No Charge	50% Coinsurance after deductible
Urgent Care	20% Coinsurance after deductible	$60 Copay after deductible	50% Coinsurance after deductible	$75 Copay after deductible	50% Coinsurance after deductible
Laboratory Tests	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$50 Copay after deductible	50% Coinsurance after deductible
X-Rays and Diagnostic Imaging	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$50 Copay after deductible	50% Coinsurance after deductible
Emergency Room Facility Fee (waived if admitted)	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	$300 Copay after deductible	$300 Copay after deductible
Emergency Room Physician Fee (waived if admitted)	0% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge
Emergency Medical Transportation	20% Coinsurance after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	$300 Copay after deductible	$300 Copay after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	20% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	20% Coinsurance after deductible	30% Coinsurance after deductible	100%	40% Coinsurance after deductible	100%
Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$250 Copay after deductible	50% Coinsurance after deductible
Tier 1 (Generic Drugs)	20% (up to $250/script after pharmacy deductible)	$19 Copay after deductible	100%	$15	100%
Tier 2 (Preferred Brand Drugs)	20% (up to $250 / script after pharmacy deductible)	$40 Copay after deductible	100%	$55 after deductible	100%
Tier 3 (Nonpreferred Brand Drugs)	20% (up to $250/script after pharmacy deductible)	$60 Copay after deductible	100%	$85 after deductible	100%
Tier 4 (Specialty Drugs)	20% (up to $250/script after pharmacy deductible)	30% after deductible (up to $250/script)	100%	40% Coinsurance after deductible (up to $250/script)	100%
Mental/Behavioral Health Outpatient Office Visits	20% Coinsurance after deductible	$40 Copay after deductible	50% Coinsurance after deductible	$30	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility Fee	20%	30% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	20% Coinsurance after deductible	$40 Copay after deductible	50% Coinsurance after deductible	$30	50% Coinsurance after deductible
Substance Use Disorder Inpatient Physician Fee	20%	30% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Inpatient Physician Fee (e.g. hospital room)	20% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Embedded Pediatric Dental	Sharp: Pediatric Dental Embedded Kaiser: Not Embedded	Embedded	Embedded	Embedded	Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	$6,550	$6,550	$13,100	$7,150	$14,300
MAXIMUM OUT-OF-POCKET FOR FAMILY	$13,100	$13,100	$26,200	$14,300	$28,600

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.

* Deductible applies after 1st three non-preventative 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. Services provided by an out-of-network provider but are approved as in-network by the carrier are considered in-network.
2) For covered out of network services in a PPO plan, the Patient Centered Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable carrier's 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 carrier'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 $2,700 for Plan Year 2018. 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 | FOR SMALL BUSINESS

2018 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Bronze (60%)	•Health Net 60 6300/75 (PPO) •Blue Shield 60 6300/75 (PPO) •Sharp 60 6300/75 (Performance HMO)	(OON) = Out of Network •Health Net 60 6300/75 (OON) •Blue Shield 60 6300/75 (OON)	•Kaiser 60 6300/75 (HMO) •CCHP 60 6300/75 (HMO)	•Kaiser 60 HDHP 4800/40% (HMO) •Sharp 60 HDHP 4800/40% (Premier HMO) •CCHP 60 HDHP 4800/40% (HMO)	(OON) = Out of Network •Health Net 60 HDHP 5600/15 Alt (PPO) - *NEW 2018* •Health Net 60 HDHP 5600/15 Alt (EnhancedCare PPO) - *NEW 2018*	
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	$4,800 Integrated	$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	$9,600 Integrated	$11,200	$22,400
Preventative Care/Screening/ Immunization	No Charge	100%	No Charge	No Charge	No Charge	100%
Primary care visit to treat an injury, illness or condition	$75*	50% Coinsurance after deductible	$75*	40% Coinsurance after deductible	$15 Copay after deductible	50% Coinsurance after deductible
Specialist visit	$105*	50% Coinsurance after deductible	$105*	40% Coinsurance after deductible	$30 Copay 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	$75*	Health Net: 50% Coinsurance after deductible Blue Shield: 100% after deductible	$75*	40% Coinsurance after deductible	$30 Copay after deductible	50% Coinsurance after deductible
Laboratory Tests	$40	50% Coinsurance after deductible	$40	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
X-Rays and Diagnostic Imaging	100% Coinsurance after deductible	Health Net: 100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% 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	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	No Charge	No Charge
Emergency Medical Transportation	100% Coinsurance after deductible	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	100% Coinsurance after deductible	Health Net:100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Physician/Surgeon Fee	100% Coinsurance after deductible	Health Net: 100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	10% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	100% Coinsurance after deductible	Health Net: 100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Facility Fee (e.g. hospital room)	100% Coinsurance after deductible	Health Net: 100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	100% Coinsurance after deductible	100%	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	100%
Imaging (CT/PET scans, MRIs)	100% Coinsurance after deductible	Health Net: 100% Coinsurance after deductible Blue Shield:50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Tier 1 (Generic Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	$5 Copay after deductible	100%
Tier 2 (Preferred Brand Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	$15 Copay after deductible	100%
Tier 3 (Nonpreferred Brand Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	$40 Copay after deductible	100%
Tier 4 (Specialty Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	20% Coinsurance after deductible (up to $500)	100%
Mental/Behavior Health Outpatient office visits	$75 after deductible* Health Net: No Charge	50% Coinsurance after deductible	$75*	40% Coinsurance after deductible	$15 Copay after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient physician fee	100% Coinsurance after deductible	Health Net:100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility fee	100% Coinsurance after deductible	Health Net: 100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Outpatient office visits	$75 after deductible* Health Net: No Charge	Health Net:100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	$75*	40% Coinsurance after deductible	$15 Copay after deductible	50% Coinsurance after deductible
Substance Use Inpatient Physican Fee	100% Coinsurance after deductible	Health Net:100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Inpatient Facility Fee (e.g. hospital room)	100% Coinsurance after deductible	Health Net: 100% Coinsurance after deductible Blue Shield: 50% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Kaiser: Not Embedded Sharp: Embedded	Kaiser: Not Embedded Sharp: Embedded	Embedded	Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	$7,000	Health Net: $12,600 Blue Shield: $10,000	$7,000	$6,550	$6,550	$13,100
MAXIMUM OUT-OF-POCKET FOR FAMILY	$14,000	Health Net: $25,200 Blue Shield: $20,000	$14,000	$13,100	$13,100	$26,200

✓ *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.

* 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. Services provided by an out-of-network provider but are approved as in-network by the carrier are considered in-network.
2) For covered out of network services in a PPO plan, the Patient Centered Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable carrier's 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 carrier'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 $2,700 for Plan Year 2018. 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.