COVERED CALIFORNIA SMALL BUSINESS

2022 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 0/20 (HMO) •Blue Shield 0/20 (Trio HMO) •Sharp 0/20 (Premier HMO)	•Kaiser 0/10 Alt (HMO)
Service Type	**In-Network**	**Out-of- Network**	**In-Network**	**In-Network**
Individual Deductible (if any)	$0	$1,000	$0	$0
Family Deductible (if any)	$0	$2,000	$0	$0
Preventive Care/ Screening/Immunization	No Charge	Blue Shield: 100% Health Net: 50% Coinsurance after deductible	No Charge	No Charge
Primary Care Visit to treat an injury, illness, or Condition	$15	50% Coinsurance after deductible	$20	$10
Other Practitioner Office Visit	$15	50% Coinsurance after deductible	$20	$10
Specialist Visit	$30	50% Coinsurance after deductible	$30	$20
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge
Urgent Care	$15	50% Coinsurance after deductible	$20	$10
Laboratory Tests	$15	50% Coinsurance after deductible	$20	$20
X-Ray and Diagnostic Imaging	$30	50% Coinsurance after deductible	$30	$40
Emergency Room Facility Fee (waived if admitted)	$200	$200	$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%	50% Coinsurance after deductible	$100 Kaiser: $125	$300
Outpatient Physician/Surgeon Fee	10%	50% Coinsurance after deductible	$25 Kaiser: No Charge	No Charge
Outpatient Visit	10%	50% Coinsurance after deductible	10%	No Charge
Inpatient Physician/Surgeon Fee	10%	50% Coinsurance after deductible	No Charge	No Charge
Inpatient Facility Fee (e.g. hospital room)	10%	50% Coinsurance after deductible	$250 Copay per day (up to 5 days)	$500 Copay per admission
Durable Medical Equipment	10%	50% Coinsurance after deductible	10%	10%
Imaging (CT/PET scans, MRIs)	10%	50% Coinsurance after deductible	$100	$150
Tier 1 (Generic Drugs)	$10	100%	$5 Blue Shield: Level A $5, Level B $7	$5
Tier 2 (Preferred Brand Drugs)	$25	100%	$20 Blue Shield: Level A $20, Level B $35	$15
Tier 3 (Nonpreferred Brand Drugs)	$40	100%	$30 Kaiser:$20 Blue Shield: Level A $30, Level B $50	$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	50% Coinsurance after deductible	$20	$10
Mental/Behavior Health Inpatient Physician Fee	10%	50% Coinsurance after deductible	No Charge	No Charge
Mental/Behavior Health Inpatient Facility Fee	10%	50% Coinsurance after deductible	$250 Copay per day (up to 5 days)	$500 Copay per admission
Substance Use Disorder Outpatient Office Visits	$15	50% Coinsurance after deductible	$20	$10
Substance Use Inpatient Physician Fee	10%	50% Coinsurance after deductible	No Charge	No Charge
Substance Use Inpatient Facility Fee (e.g. hospital room)	10%	50% Coinsurance after deductible	$250 per day (up to 5 days)	$500 Copay per admission

Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Sharp, Blue Shield: Pediatric Dental Embedded Kaiser: Bundled	Bundled
MAXIMUM OUT-OF-POCKET FOR ONE	$4,500	Health Net: $9,000 Blue Shield : $9,000	$4,500	$3,000
MAXIMUM OUT-OF-POCKET FOR FAMILY	$9,000	Health Net: $18,000 Blue Shield: $18,000	$9,000	$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.**

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 2022 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued