2015
Standard Benefits
Small Business Health Options Program (SHOP)

Platinum (90%)

Key Benefits	Health Net Platinum 90 PPO In Network / Sharp Platinum 90 HMO Network 2 w/Child Dental (Coinsurance)	Health Net Platinum 90 PPO Out of Network	Platinum 90 HMO Plans: Blue Shield; Chinese Community Health Plan w/ Child Dental; Kaiser Permanente; Sharp Network 1 w/Child Dental (Copay); Western Health Advantage w/Child Dental	
	Benefits in Blue are Subject to Deductibles	Copays in the Yellow Sections are Not Subject to Any Deductible and Count Toward the Annual Out-of-Pocket Maximum		
Deductible (if any)	$0	$0 single / $0 family	Blue Shield; Chinese Community Health Plan; Sharp; Western Health Advantage	Kaiser Permanente
			$0	$0
Preventative Care Copay	No cost share	Not covered	No cost share	No cost share
Primary Care Visit Copay	$20	50%	$20	$20
Specialty Care Visit Copay	$40	50%	$40	$40
Prenatal Care and Preconception Visit	No cost share	50%	No cost share	No cost share
Urgent Care Visit Copay	$40	$40	$40	$20
Lab Testing Copay	$20	50%	$20	$20
X-Ray Copay	$40	50%	$40	$40
Emergency Room Copay (waived if admitted)	$150	$150	$150	$150
Outpatient Hospital Facility Fee	10%	50%	$250	$250
Physician/Surgeon Fees	10%	50%	$0	$0
Hospital Stay Facility Fee	10%	50%	$250 per day (up to 5 days)	$250 per day (up to 5 days)
Durable Medical Equipment	10%	Not covered	10%	10%
Imaging (MRI, CT, PET Scans)	10%	50%	$150	$150
Generic Medication Copay	$5	Not covered	$5	$5
Preferred Brand Copay	$15	Not covered	$15	$15
Non-Preferred Brand Copay	$25	Not covered	$25	$15
Mental/Behavior Health Outpatient Services	$20	50%	$20	$20
Mental/Behavioral Health Inpatient Services	10%	50%	$250 per day up to 5 days	$250 per day up to 5 days
Substance Use Disorder Outpatient Services	$20	50%	$20	$20
Substance Use Disorder Inpatient Services	10%	50%	$250 per day up to 5 days	$250 per day up to 5 days
MAXIMUM OUT-OF-POCKET FOR ONE	$4,000	$8,000	$4,000	
MAXIMUM OUT-OF-POCKET FOR FAMILY	$8,000	$16,000	$8,000	

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* Non-Preferred Brand Copay
** Deductible waived first three visits; $70 after deductible.
*** Deductible waived first three visits.

Notes
1) Family deductibles and out-of-pocket maximums are equal to two times the individual values. Except for High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible for only the single out-of-pocket deductible and a single out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out-of-pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under the HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
4) For Bronze and Catastrophic plans, the deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category

2015
Standard Benefits
Small Business Health Options Program (SHOP)

Key Benefits	Gold (80%)					
	Health Net Gold 80 PPO In Network Sharp Gold 80 HMO Network 2 w/Child Dental (Coinsurance)	Health Net Gold 80 PPO Out of Network	Gold 80 HMO Plans: Blue Shield; Chinese Community Health Plan w/ Child Dental; Kaiser Permanente; Sharp Network 1 w/Child Dental (Copay); Western Health Advantage w/Child Dental		Health Net Gold 80 EPO Alternate	Kaiser Permanente Gold 80 HMO Alternate
	Benefits in Blue are Subject to Deductibles		Copays in the Yellow Sections are Not Subject to Any Deductible and Count Toward the Annual Out-of-Pocket Maximum			
Deductible (if any)	$0	$0	Blue Shield; Chinese Community Health Plan; Sharp; Western Health Advantage $0	Kaiser Permanente $0	$1,000/$2,000	$500
Preventative Care Copay	No cost share	Not covered	No cost share	No cost share	No cost share	No cost share
Primary Care Visit Copay	$30	50%	$30	$30	$20	$30
Specialty Care Visit Copay	$50	50%	$50	$50	$30	$30
Prenatal Care and Preconception Visit	No cost share	50%	No cost share	No cost share	$20	No cost share
Urgent Care Visit Copay	$60	50%	$60	$30	$60	$30
Lab Testing Copay	$30	50%	$30	$30	$20	$20
X-Ray Copay	$50	50%	$50	$50	$30	$20
Emergency Room Copay (waived if	$250	$250	$250	$250	$175	$250
Outpatient Hospital Facility Fee	20%	50%	$600	$600	20%	$600
Physician/Surgeon Fees	20%	50%	$0	$0	20%	$0
Hospital Stay Facility Fee	20%	50%	$600 per day up to 5 days	$600 per day up to 5	20%	$600 per day up to 5 days
Durable Medical Equipment	20%	Not covered	20%	20%	20%	20% for DME base; 20% after deductible (up to $2,000 annual maximum for supplemental DME)
Imaging (MRI, CT, PET Scans)	20%	50%	$250	$250	20%	$250
Generic Medication Copay	$15	Not covered	$15	$15	$5	$15
Preferred Brand Copay	$50	Not covered	$50	$50	$15	$50
Non-Preferred Brand Copay	$70	Not covered	$70	$50	20%	$50
Mental/Behavior Health Outpatient	$30	50%	$30	$30	$20	$30
Mental/Behavioral Health Inpatient Services	20%	50%	$600 per day up to 5 days	$600 per day up to 5 days	20%	$600 per day up to 5 days
Substance Use Disorder Outpatient Services	$30	50%	$30	$30	$20	$30
Substance Use Disorder Inpatient Services	20%	50%	$600 per day up to 5 days	$600 per day up to 5 days	20%	$600 per day up to 5 days
MAXIMUM OUT-OF-POCKET FOR ONE	$6,250	$12,500	$6,250		$6,250	$6,250
MAXIMUM OUT-OF-POCKET FOR FAMILY	$12,500	$25,000	$12,500		$12,500	$12,500

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*** Deductible waived first three visits.

Notes

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7) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
8) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
9) For Bronze and Catastrophic plans, the deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits
10) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

2015
Standard Benefits
Small Business Health Options Program (SHOP)

Silver (70%)

Key Benefits	Health Net Silver 70 PPO In Network Sharp Silver 70 HMO Network 2 w/Child Dental (Coinsurance)	Health Net Silver 70 PPO Out of Network	Silver 70 HMO Plans: Blue Shield; Chinese Community Health Plan w/Child Dental; Kaiser Permanente; Sharp Network 1 w/Child Dental (Copay); Western Health Advantage w/Child Dental	Silver 70 H.S.A. HMO Plans: Kaiser Permanente; Sharp Network 1 w/Child Dental (Coinsurance); Western Health Advantage w/Child Dental		Health Net Silver 70 H.S.A. EPO Alternate Plan	Kaiser Permanente Silver 70 HMO Network 2 Alternate Plan
	Benefits in Blue are Subject to Deductibles		Copays in the Yellow Sections are Not Subject to Any Deductible and Count Toward the Annual Out-of-Pocket Maximum				
				Sharp; Western Health Advantage	Kaiser Permanente		
Deductible (if any)	$1,500/$3,000 Medical / $500 Brand Drugs	$3,000/$6,000	$1,500 Medical / $500 Brand Drugs	$1,500/$3,000 integrated Med/Rx	$1,500/$3,000 integrated Med/Rx	$1,500/$3,000 integrated Med/Rx	$1,000
Preventative Care Copay	No cost share	Not covered	No cost share	No cost share	No cost share	No cost share	No cost share
Primary Care Visit Copay	$45	50%	$45	20%	20%	30%	$40
Specialty Care Visit Copay	$65	50%	$65	20%	20%	30%	$40
Prenatal Care and Preconception Visit	No cost share	50%	No cost share	No cost share	No cost share		No cost share
Urgent Care Visit Copay	$90	50%	$90	20%	20%	30%	$40
Lab Testing Copay	$45	50%	$45	20%	20%	30%	$30
X-Ray Copay	$65	50%	$65	20%	20%	30%	$40
Emergency Room Copay (waived if admitted)	$250	$250	$250	20%	20%	30%	30%
Outpatient Hospital Facility Fee	20%	50%	20%	20%	20%	30%	30%
Physician/Surgeon Fees	20%	50%	20%($0 KP)	20%	20%	30%	$0
Hospital Stay Facility Fee	20%	50%	20%	20%	20%	30%	30%
Durable Medical Equipment	20%	Not covered	20%	20%	20%	30%	30%
Imaging (MRI, CT, PET Scans)	20%	50%	$250	20%	20%	30%	30%
Generic Medication Copay	$15	Not covered	$15	20%	20%	30%	$25
Preferred Brand Copay	$50	Not covered	$50	20%	20%	30%	$50
Non-Preferred Brand Copay	$70	Not covered	$70	20%	20%	30%	$50
Mental/Behavior Health Outpatient Services	$45	50%	$45	20%	20%	30%	$40
Mental/Behavioral Health Inpatient Services	20%	50%	20%	20%	20%	30%	30%
Substance Use Disorder Outpatient Services	$45	50%	$45	20%	20%	30%	$40
Substance Use Disorder Inpatient Services	20%	50%	20%	20%	20%	30%	30%
MAXIMUM OUT-OF-POCKET FOR ONE	$6,250	$12,500	$6,250	$6,250		$6,000	$6,250
MAXIMUM OUT-OF-POCKET FOR FAMILY	$12,500	$25,000	$12,500	$12,500		$12,000	$12,500

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* Non-Preferred Brand Copay
** Deductible waived first three visits; $70 after deductible.
*** Deductible waived first three visits.

Notes

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2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
4) For Bronze and Catastrophic plans, the deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
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2015
Standard Benefits
Small Business Health Options Program (SHOP)

Bronze (60%)

Key Benefits	Bronze 60 PPO Plans: Blue Shield; Health Net In Network Sharp HMO Network 2 w/Child Dental (Coinsurance) In Network	Bronze 60 PPO Plans: Blue Shield; Health Net Out of Network	Bronze 60 HMO Plan: Chinese Community Health Plan w/ Child Dental; Kaiser Permanente; Western Health Advantage w/Child Dental		Bronze 60 H.S.A. HMO Plans: Kaiser Permanente; Sharp Network 1 w/Child Dental (Coinsurance)		Western Health Advantage Bronze 60 H.S.A. HMO w/Child Dental Alternate Plan
	Benefits in Blue are Subject to Deductibles		Copays in the Yellow Sections are Not Subject to Deductible and Count Toward the Annual Out-of-Pocket Maximum				
			Chinese Community Health Plan; Western Health Advantage	Kaiser Permanente	Sharp	Kaiser Permanente	
Deductible (if any)	$5,000/$10,000 integrated Med/RX	$10,000/20,000	$5,000/$10,000 integrated Med/RX	$5,000/$10,000 integrated Med/RX	$4,500/$9,000 integrated Med/RX	$4,500/$9,000 integrated Med/RX	$5,500/$11,000
Preventative Care Copay	No cost share	Not Covered	No cost share	No cost share	No cost share	No cost share	No cost share
Primary Care Visit Copay	$60**	50%	$60**	$60**	40%	40%	0%
Specialty Care Visit Copay	$70	50%	$70	$70	40%	40%	0%
Prenatal Care and Preconception Visit	No cost share	50%	No cost share	No cost share	No cost share	No cost share	0%
Urgent Care Visit Copay	$120***	50% (Not covered by Blue Shield)	$120	$60	40%	40%	0%
Lab Testing Copay	30%	50%	30%	30%	40%	40%	0%
X-Ray Copay	30%	50%	30%	30%	40%	40%	0%
Emergency Room Copay (waived if admitted)	$300	$300	$300	30%	40%	40%	0%
Outpatient Hospital Facility Fee	30%	50%	30%	30%	40%	40%	0%
Physician/Surgeon Fees	30%	50%	30%	30%	40%	40%	0%
Hospital Stay Facility Fee	30%	50%	30%	30%	40%	40%	0%
Durable Medical Equipment	30%	Not Covered	30%	30%	40%	40%	0%
Imaging (MRI, CT, PET Scans)	30%	50%	30%	30%	40%	40%	0%
Generic Medication Copay	$15	Not Covered	$15	$15	40%	40%	0%
Preferred Brand Copay	$50	Not Covered	$50	$50	40%	40%	0%
Non-Preferred Brand Copay	$75	Not Covered	$75	$50	40%	40%	0%
Mental/Behavior Health Outpatient Services	$60***	50%	$60	$60	40%	40%	0%
Mental/Behavioral Health Inpatient Services	30%	50%	30%	30%	40%	40%	0%
Substance Use Disorder Outpatient Services	$60***	50%	$60	$60	40%	40%	0%
Substance Use Disorder Inpatient Services	30%	50%	30%	30%	40%	40%	0%
MAXIMUM OUT-OF-POCKET FOR ONE	$6,250	$10,000	$6,250		$6,250		$5,500
MAXIMUM OUT-OF-POCKET FOR FAMILY	$12,500	$20,000	$12,500		$12,500		$11,000

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** Deductible waived first three visits; $70 after deductible (for Kaiser Permanente $60 after deductible).
*** Deductible waived first three visits.

Notes

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8) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
9) For Bronze and Catastrophic plans, the deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
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2015
Standard Benefits
Small Business Health Options Program (SHOP)

Key Benefits	Family Dental Plan		Family Dental Plan	
	Children's Dental DHMO Plan Access Dental, Blue Shield, Delta Dental, Liberty Dental, Managed Dental Care, SafeGuard, Dental Health Services **Also available as a standalone dental plan**	**Adult Dental DHMO Plan** Access Dental, Delta Dental, Liberty Dental, Managed Dental Care, SafeGuard, Dental Health Services	**Children's Dental DPPO Plan** Blue Shield, Delta Dental, Guardian, MetLife, Premier Access **Also available as a standalone dental plan**	**Adult Dental DPPO Plan** Delta Dental, Guardian, Premier Access
	Up to Age 19	**Age 19 and Older**	**Up to Age 19**	**Age 19 and Older**
Actuarial Value	83.0%	Not Calculated	86.8%	Not Calculated
Individual Deductible (waived for Diagnostic & Preventive)	$0	$0	$65 In Network/ $65 Out of Network	$50 In Network/ $50 Out of Network
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)	$0	$0	$130 In Network/ $130 Out of Network	Not Applicable
Individual Out of Pocket Maximum	$350*	Not Applicable	$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	$700	Not Applicable	$700	Not Applicable
Office Copay	$0	$0	$0	$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)	None	None	None	6 months for Major Services, Waived with Proof of Prior Coverage
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)	None	None	None	$1,500

Procedure Category	**Service Type**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Diagnostic & Preventive	Oral Exam	$0		$0		0%		0	
	Preventive - Cleaning	$0		$0		0%		0%	
	Preventive - X-ray	$0		$0		0%		0	
	Sealants per Tooth	$0		Not Covered		0%		Not Covered	
	Topical Fluoride Application	$0		Not Covered		0%		Not Covered	
	Space Maintainers - Fixed	$0		Not Covered		0%		Not Covered	
Basic Services	Amalgam Fill - One Surface	$25		$25		20%	x	2	x
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	$300		$300					
	Gingivectomy per Quad	$150		$150					
	Extraction- Single Tooth Exposed Root or Erupted	$65		$65		50%	x	50%	x
	Extraction - Complete Bony	$160		$160					
	Crown - Porcelain with Metal	$300		$300					
Orthodontia	Medically Necessary Orthodontia	$350		Not Covered		50%	x	Not Covered	

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* Western Health Advantage, Chinese Community Health Plan, and SHARP include pediatric dental embedded. These plan benefits are illustrated in the above plan summary under Children's Dental DHMO. Please Note: The embedded Children's dental plan out of pocket maximum is different from the stand alone plans. Children's dental expenses will be applied to the medical out of pocket maximum.

Pediatric Dental Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
2) Cost sharing payments made by each individual child for in- network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of- pocket maximum.
4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

5) Each adult is responsible for an individual deductible.
6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.