COVERED CALIFORNIA FOR SMALL BUSINESS

2019 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) •CCHP 0/15 (HMO) •Blue Shield 0/15 (Trio HMO) •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	Health Net: $1,000 Blue Shield: $0	$0	$250	$1,000	$0
Family Deductible (if any)	$0	Health Net: $2,000 Blue Shield: $0	$0	$500	$2,000	$0
Preventative Care/ Screening/Immunization	No Charge	100%	No Charge	No Charge	100%	No Charge
Primary Care Visit to treat an injury, illness, or Condition	$15	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$15	50% Coinsurance after deductible	$10
Specialist Visit	$30	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$30	$30	50% Coinsurance after deductible	$20
Prenatal Care and Preconception Visit	No Charge	Health Net: 50% Coinsurance after deductible Blue Shield 50%	No Charge	No Charge	50% Coinsurance after deductible	No Charge
Urgent Care	$15	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$30	50% Coinsurance after deductible	$10
Laboratory Tests	$15	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$15	$30	50% Coinsurance after deductible	$20
X-Ray and Diagnostic Imaging	$30	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$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	No Charge	No Charge	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%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$100	10% Coinsurance after deductible	50% Coinsurance after deductible	$300
Outpatient Physician/Surgeon Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$25	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge
Inpatient Physician/Surgeon Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge
Inpatient Facility Fee (e.g. hospital room)	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$250 Copay per day (up to 5 days)	10% Coinsurance after deductible	50% Coinsurance after deductible	$500 per admission
Durable Medical Equipment	10%	Health Net: 100% Blue Shield: 50%	10%	10% Coinsurance after deductible	100%	10%
Imaging (CT/PET scans, MRIs)	10%	Health Net: 50% Coinsurance after deductible Blue Shield 50%	$75	10% Coinsurance after deductible	50% Coinsurance after deductible	$150
Tier 1 (Generic Drugs)	$5	100%	$5	$5	100%	$5
Tier 2 (Preferred Brand Drugs)	$15	100%	$15	$30	100%	$15
Tier 3 (Nonpreferred Brand Drugs)	$25	100%	$25 Kaiser:$15	$50	100%	$15
Tier 4 (Specialty Drugs)	10% (up to $250 per script)	100%	10% (up to $250 per script)	10%	100%	10% (up to $250 per script)
Mental/Behavior Health Outpatient Office Visits	Health Net, Sharp: No Charge Blue Shield: $15	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	$15 Sharp: No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	$10
Mental/Behavior Health Inpatient Physician Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	No Charge
Mental/Behavior Health Inpatient Facility Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	$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	Health Net, Sharp: No Charge Blue Shield: $15	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	$15 Sharp: No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	$10
Substance Use Inpatient Physician Fee	10%	Health Net: 50% Coinsurance after deductible Blue Shield: 50%	No Charge	10% Coinsurance after deductible	50% Coinsurance after deductible	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)	10% Coinsurance after deductible	50% Coinsurance after deductible	$500 Copay per admission
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Sharpe, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$3,350**	**Health Net: $9,000 Blue Shield : $6,700**	**$3,350**	**$3,600**	**$9,000**	**$3,000**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$6,700**	**Health Net: $18,000 Blue Shield: $13,400**	**$6,700**	**$7,200**	**$18,000**	**$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.**

* 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. Innetwork 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 2019 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 | FOR SMALL BUSINESS

2019 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Gold (80%)	•Health Net 0/30 (PPO) •Blue Shield 0/30 (PPO) •Sharp 0/30 (Performance HMO)	(OON) = Out of Network •Health Net 0/30 (OON) •Blue Shield 0/30 (OON)	(OON) = Out of Network •Health Net 750/10 Alt (Value PPO)		(OON) = Out of Network Health Net 1000/30 Alt (EnhancedCare PPO)		•Kaiser 0/30 (HMO) •CCHP 0/30 (HMO) •Blue Shield 0/30 (Trio HMO) •Sharp 0/30 (Premier HMO)	•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**
Individual Deductible (if any)	$0	Health Net: $2000 Blue Shield: $0	$750	$2,250	$1,000	$2,000	$0	$500
Family Deductible (if any)	$0	Health Net: $4,000 Blue Shield: $0	$1,500	$4,500	$2,000	$4,000	$0	$1,000
Preventative Care/Screening/ Immunization	No Charge	100%	No Charge	100%	No Charge	100%	No Charge	No Charge
Primary Care Visit to treat an injury, illness or condition	$30	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$10	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$30	$30
Specialist Visit	$55	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$30 Copay after deductible	50% Coinsurance after deductible	$50	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	50% Coinsurance after deductible	No Charge	No Charge
Urgent Care	$30	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$30 Copay after deductible	50% Coinsurance after deductible	$50	50% Coinsurance after deductible	$30	$30
Laboratory Tests	$35	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$20 Copay after deductible	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$35	$20
X-Rays and Diagnostic Imaging	$55	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$20 Copay after deductible	50% Coinsurance after deductible	$35	50% Coinsurance after deductible	$55	$40
Emergency Room Facility Fee (waived if admitted)	$325	$325	$250 Copay after deductible	$250 Copay after deductible	30% Coinsurance after deductible	30% Coinsurance after deductible	$325	$250 Copay after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Emergency Medical Transportation	$250	$250	$250 Copay after deductible	$250 Copay after deductible	30% Coinsurance after deductible	30% Coinsurance 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% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance 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%	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$40	No Charge
Inpatient Physician/ Surgeon Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	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% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	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% Coinsurance after deductible	100%	30% Coinsurance after deductible	100%	20%	20%
Imaging (CT/PET scans, MRIs)	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$150 Copay after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$275	$300 Copay after deductible
Tier 1 (Generic Drugs)	$15	100%	$10	100%	$15	100%	$15	$15
Tier 2 (Preferred Brand Drugs)	$55	100%	$25 Copay after deductible	100%	$30	100%	$55	$50
Tier 3 (Nonpreferred Brand Drugs)	$75	100%	$50 Copay after deductible	100%	$50	100%	$75 Kaiser: $55	$50
Tier 4 (Specialty Drugs)	20% (up to $250 / script)	100%	30% Coinsurance after deductible (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	Health Net, Sharp: No Charge Blue Shield: $30	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$10	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$30 Sharp: No Charge	$30
Mental/Behavior Health Inpatient Physician Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance 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% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	50% Coinsurance after deductible	$600 / day (up to 5 days)	$600 / day (up to $3,000 / admission)
Substance Use Disorder Outpatient Office Visits	Health Net, Sharp: No Charge Blue Shield: $30	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	$10	50% Coinsurance after deductible	$30	50% Coinsurance after deductible	$30 Sharp: No Charge	$30
Substance Use Inpatient Physician Fee	20%	Health Net: 50% Coinsurance after deductible Blue Shield : 50%	30% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance after deductible	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% Coinsurance after deductible	50% Coinsurance after deductible	30% Coinsurance 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	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$7,200**	**Health Net: $14,400 Blue Shield: $12,550**	**$7,150**	**$14,300**	**$7,200**	**$14,400**	**$7,200**	**$7,000**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$14,400**	**Health Net: $28,800 Blue Shield: $25,100**	**$14,300**	**$28,600**	**$14,400**	**$28,800**	**$14,400**	**$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. Innetwork 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 2019 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 FOR SMALL BUSINESS

2019 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Silver (70%)	•Health Net 2000/45 (PPO) •Blue Shield 2000/45 (PPO) •Sharp 2000/45 (Performance HMO)	(OON) = Out of Network •Health Net 2000/45 (OON) •Blue Shield 2000/45 (OON)	•Kaiser Silver 2000/45 (HMO) •CCHP Silver 2000/45 (HMO) •Sharp 2000/45 (Premier HMO) •Blue Shield 2000/45 (Trio HMO)	(OON) = Out of Network •Health Net 2000/55 Alt (EnhancedCare PPO)		•Kaiser 1000/55 Alt (HMO)
Service Type	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**	**Out-of-Network**	**In-Network**
Individual Deductible (if any)	$2,000 Medical/ **$200 Pharmacy**	$4,000 Medical	$2,000 Medical/ **$200 Pharmacy**	$2,000 Medical/**$300 Pharmacy**	$4,000	$1,000 Medical/ **$250 Pharmacy**
Family Deductible (if any)	$4,000 Medical/ **$400 Pharmacy**	$8,000 Medical	$4,000 Medical/ **$400 Pharmacy**	$4,000 Medical/**$600 Pharmacy**	$8,000	$2,000 Medical/ **$500 Pharmacy**
Preventative Care/Screening/Immunization	No Charge	100%	No Charge	No Charge	100%	No Charge
Primary Care Visit to treat an injury, illness or condition	$45	50% Coinsurance after deductible	$45	$55	50% Coinsurance after Deductible	$55
Specialist Visit	$80	50% Coinsurance after deductible	$80	$75	50% Coinsurance after Deductible	$75
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	50% Coinsurance after Deductible	No Charge
Urgent Care	$45	50% Coinsurance after deductible	$45	$75	50% Coinsurance after Deductible	$55
Laboratory Tests	$40	50% Coinsurance after deductible	$40	$40	50% Coinsurance after Deductible	$50
X-Rays and Diagnostic Imaging	$75	50% Coinsurance after deductible	$75	$65	50% Coinsurance after Deductible	$70
Emergency Room Facility Fee (waived if admitted)	$350	$350	$350	40% Coinsurance after deductible	40% Coinsurance after deductible	35% 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	35% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	20%	50% Coinsurance after deductible	20%	40% Coinsurance after deductible	50% Coinsurance after Deductible	35% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible	20%	40% Coinsurance after deductible	50% Coinsurance after Deductible	35% Coinsurance after deductible
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	35% 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	35% Coinsurance after deductible
Durable Medical Equipment	20%	Health Net: 100% Blue Shield: 50% Coinsurance after deductible	20%	40% Coinsurance after deductible	100%	35%
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)	$15 Copay after pharmacy deductible	100%	$15 Copay after pharmacy deductible	$15	100%	$30
Tier 2 (Preferred Brand Drugs)	$55 Copay after pharmacy deductible	100%	$55 Copay after pharmacy deductible	$65	100%	$75 Copay after deductible
Tier 3 (Nonpreferred Brand Drugs)	$85 Copay after pharmacy deductible	100%	$85 Kaiser: $55 Copay after deductible (up to $250/script after pharmacy deductible)	$85	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 deductible	100%	20% (up to $250 / script) after pharmacy deductible
Mental/Behavioral Health Outpatient Office Visits	Health Net: No Charge Blue Shield/Sharp: $45	50% Coinsurance after deductible	$45 Sharp: No Charge	$55	50% Coinsurance after Deductible	$55
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible Sharp: 20%	40% Coinsurance after deductible	50% Coinsurance after Deductible	35% 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	35% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	Health Net: No Charge Blue Shield/Sharp: $45	50% Coinsurance after deductible	$45 Sharp: No Charge	$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	35% 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	35% Coinsurance after deductible
Embedded Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	CCHP, Sharp, Blue Shield: Pediatric Dental Embedded Kaiser: Not Embedded	Embedded	Embedded	Not Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	**$7,550**	**Health Net: $15,100** **Blue Shield: $12,550**	**$7,550**	**$7,350**	**$14,700**	**$7,550**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$15,100**	**Health Net: $30,200** **Blue Shield: $25,100**	**$15,100**	**$14,700**	**$29,400**	**$15,100**

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. Innetwork 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 2019 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 FOR SMALL BUSINESS

2019 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 1350/40 Alt (PPO) •Health Net HDHP 1350/40 Alt (EnhancedCare PPO)		•Kaiser HDHP 2500/20% (HMO) •Sharp Premier HDHP 2500/20% (HMO)	•Kaiser 1800/55 Alt (HMO) - NEW 2019	(OON) = Out of Network •Health Net 1700/30 Alt (Value PPO)	
Service Type	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Individual Deductible (if any)	$1,350	$2,700	$2,500 Integrated Kaiser: ($2,700 if enrolled with family coverage)	$1,800 Medical/**$350 Pharmacy**	$1,700	$3,400
Family Deductible (if any)	$2,700	$5,400	$5,000 Integrated	$3,600 Medical/**$700 Pharmacy**	$3,400	$6,800
Preventative Care/Screening/Immunization	No Charge	100%	No Charge	No Charge	No Charge	100%
Primary Care Visit to treat an injury, illness or condition	$40 Copay after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55	$30	50% Coinsurance after deductible
Specialist Visit	$60 Copay after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$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	50% Coinsurance after deductible
Urgent Care	$60 Copay after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55	$75 Copay after deductible	50% Coinsurance after deductible
Laboratory Tests	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$50 Copay after deductible	$50 Copay after deductible	50% Coinsurance after deductible
X-Rays and Diagnostic Imaging	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$55 Copay after deductible	$50 Copay after deductible	50% Coinsurance after deductible
Emergency Room Facility Fee (waived if admitted)	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	$300 Copay after deductible	$300 Copay after deductible
Emergency Room Physician Fee (waived if admitted)	30% Coinsurance after deductible	30% Coinsurance after deductible	Kaiser: 20% Coinsurance after deductible Sharp: No Charge after Deductible	No Charge	No Charge	No Charge
Emergency Medical Transportation	30% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	$300 Copay after deductible	$300 Copay after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Facility Fee (e.g., hospital room)	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	30% Coinsurance after deductible	100%	20% Coinsurance after deductible	45%	40% Coinsurance after deductible	100%
Imaging (CT/PET scans, MRIs)	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	$350 Copay after deductible	$250 Copay 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)	$30	$15	100%
Tier 2 (Preferred Brand Drugs)	$40 Copay after deductible	100%	20% Coinsurance after deductible (up to $250/script after medical deductible)	$75 Copay after deductible	$55 Copay after deductible	100%
Tier 3 (Nonpreferred Brand Drugs)	$60 Copay after deductible	100%	20% Coinsurance after deductible (up to $250/script after medical deductible)	$75 Copay after deductible	$85 Copay after deductible	100%
Tier 4 (Specialty Drugs)	30% Coinsurance after deductible (up to $250/script)	100%	20% Coinsurance after deductible (up to $250/script after medical deductible)	20% Coinsurance after deductible (up to $250/script	40% Coinsurance after deductible (up to $250/script)	100%
Mental/Behavioral Health Outpatient Office Visits	30% Coinsurance after deductible	50% Coinsurance after deductible	Kaiser: 20% Coinsurance after deductible Sharp: No Charge	$55	$30	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Physician Fee	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility Fee	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	30% Coinsurance after deductible	50% Coinsurance after deductible	Kaiser: 20% Coinsurance after deductible Sharp: No Charge	$55	$30	50% Coinsurance after deductible
Substance Use Disorder Inpatient Physician Fee	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% Coinsurance after deductible	40% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Inpatient Facility Fee (e.g., hospital room)	30% Coinsurance after deductible	50% Coinsurance after deductible	20% Coinsurance after deductible	45% 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
MAXIMUM OUT-OF-POCKET FOR ONE	**$6,550**	**$13,100**	**$6,650**	**$7,550**	**$7,150**	**$14,300**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$13,100**	**$26,200**	**$13,300**	**$15,100**	**$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. Innetwork 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 2019 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 | FOR SMALL BUSINESS

2019 Plan Summary

Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Bronze (60%)	•Health Net 6300/75 (PPO) •Blue Shield 6300/75 (PPO) •Sharp 6300/75 (Performance HMO)	(OON) = Out of Network •Health Net 6300/75 (OON) •Blue Shield 6300/75 (OON)	•Kaiser 6300/75 (HMO) •CCHP 6300/75 (HMO)	•Kaiser HDHP 6000/40% (HMO) •Sharp HDHP 6000/40% (Premier HMO) •CCHP HDHP 6000/40% (HMO)	(OON) = Out of Network •Health Net HDHP 5600/15 Alt (PPO) •Health Net HDHP 5600/15 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	$6,000 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	$12,000 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 Copay with deductible*	50% Coinsurance after deductible	$75 Copay with deductible*	40% Coinsurance after deductible	$15 Copay after deductible	50% Coinsurance after deductible
Specialist visit	$105 Copay after deductible*	50% Coinsurance after deductible	$105 Copay after deductible*	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 Copay after deductible*	50% Coinsurance after deductible	$75 Copay after deductible*	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	20% Coinsurance after deductible	20% Coinsurance after deductible
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	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	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	100% Coinsurance after deductible	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	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	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% Coinsurance after deductible**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	$5 Copay after deductible	100%
Tier 2 (Preferred Brand Drugs)	100% Coinsurance after deductible**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	$15 Copay after deductible	100%
Tier 3 (Nonpreferred Brand Drugs)	100% Coinsurance after deductible**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	$40 Copay after deductible	100%
Tier 4 (Specialty Drugs)	100% Coinsurance after deductible**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible **	20% Coinsurance after deductible (up to $500)	100%
Mental/Behavior Health Outpatient office visits	Health Net, Sharp: No Charge Blue Shield: $75 with deductible*	50% Coinsurance after deductible	$75 Copay after deductible*	40% Coinsurance after deductible	$15 Copay after deductible	50% Coinsurance after deductible
Mental/Behavior Health Inpatient physician fee	100% Coinsurance after deductible	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	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	Health Net, Sharp: No Charge Blue Shield: $75 with deductible*	50% Coinsurance after deductible	$75 Copay after deductible*	40% Coinsurance after deductible	$15 Copay after deductible	50% Coinsurance after deductible
Substance Use Inpatient Physician Fee	100% Coinsurance after deductible	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	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	**$7,550**	**Health Net: $15,100** **Blue Shield: $12,550**	**$7,550**	**$6,650**	**$6,550**	**$13,100**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$15,100**	**Health Net: $30,200** **Blue Shield: $25,100**	**$15,100**	**$13,300**	**$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. Innetwork 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 2019 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.