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.

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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

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