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.