Benefit Summaries

Small Business Private Exchange

For Groups of 1-100 Employees

Groups Beginning 12/1/18

CONTENTS

About this Guide 2

Platinum EPO 3

Gold EPO 5

Silver EPO 7

Bronze EPO 9

The benefits listed in this brochure were collected from all plans participating in the CaliforniaChoice® Program and are accurate to the best of our knowledge at the time of print. If the information in this brochure differs from the information in the SBC (Summary of Benefits and Coverage), EOC (Evidence of Coverage) or COI (Certificate of Insurance), the EOC or COI applies.

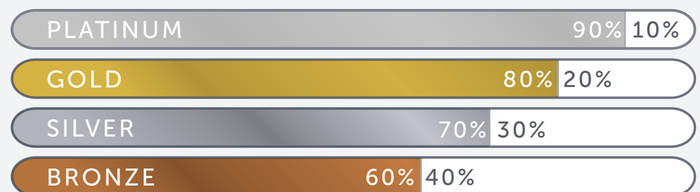
TRUSTED BY CALIFORNIANS FOR OVER 20 YEARS.

When we started California*Choice*® in 1996, the idea of offering a program that provided small businesses and their employees access to multiple health insurance carriers and benefits was truly revolutionary. Today, we're pleased to offer eight health plans and more than 80 PPO, HMO, HSP, EPO, and HSA plan design options.

GREATER ACCESS TO DOCTORS, SPECIALISTS, AND HOSPITALS

One tier or two? California*Choice* offers health plans in all four metal tiers (Platinum, Gold, Silver, and Bronze). Each tier offers a different shared health care cost percentage, as shown. We also offer **Tiered Choice**, which gives your employees **a choice of *two* tiers** (Platinum/Gold, Gold/Silver, Silver/Bronze) rather than just one. This can significantly increase the number of plans and doctors your employees can access.

METAL TIERS: (% Paid by Health Plan / Employee)



Please keep in mind that some plans may pay a different percentage of health care costs than what is shown for a specific tier; refer to each plan's summary of benefits for specific covered percentage details.

THREE STEPS TO ENROLL:

1 Choose your Metal Tier(s)

Give your employees access to the health plans and benefits available in a **single metal tier** or **two neighboring metal tiers**.

OPTION 1: SINGLE METAL TIERS:

OPTION 2: TIERED CHOICE:

2 Define Your Monthly Contribution

Your broker will share plan premium information with you. Select your preferred plan and whether you want to pay a **Fixed Percentage** of costs (select from 50% to 100%) or a **Fixed Dollar Amount** toward that plan.

3 Employees Select Their Benefits

After you select your metal tier(s) and define your contribution, each employee is provided with a personalized worksheet that spells out all options available, and the specific costs involved. Your employees also have access to other tools at calchoice.com that make it easy to determine which plans best meet their needs.

On the following pages you'll find a summary of the benefits offered in each tier level.
*For more information, please contact your broker or visit **calchoice.com**.*

Platinum EPO

Groups Beginning 12/1/18

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Platinum**	**Platinum**
Calendar Year Deductible*	None	None
Out-of-Pocket Max Ind/Fam	$3,350 / $6,700	$4,000 / $8,000
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	$15 Copay	$10 Copay
Specialist Visit (SPC)	$30 Copay	$50 Copay
Laboratory	$15 Copay	$25 Copay
X-Ray	$30 Copay	90%
MRI, CT and PET (office setting)	$75 Copay	90%
Hospital Services – In-Patient	$250 Copay per day – 5 days max	90%
In-Patient Physician Fees	100%	90%
Emergency Room (copay waived if admitted)	$150 Copay	$200 Copay
Urgent Care	$15 Copay	$50 Copay
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 $100 Copay $100 Copay	 90% 90%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	$30 Copay	$50 Copay
Ambulance Services (per trip)	$150 Copay	$200 Copay
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $5 Copay $15 Copay $25 Copay 90% (up to $250 per prescription[3])	 $10 Copay $25 Copay $50 Copay 90%
Oral Contraceptives	100%	100%
Diabetes – Self-Injectable	Applicable Rx Copay	Applicable Rx Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100%[1]	100%[1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	90%	90%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	$15 Copay	$10 Copay
Physical, Occupational, Speech Therapy	$15 Copay	$25 Copay
Rehabilitative & Habilitative Services and Devices	$15 Copay	$25 Copay
Home Health Care (Max 100 visits per year)	$20 Copay	$50 Copay

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Platinum**	**Platinum**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	$150 Copay per day – 5 days max	90%
Hospice	100%	$10 Copay
Durable Medical Equipment (Covered when medically necessary)	90%	90%
Mental Health In-Patient Out-Patient (office visit)	 $250 Copay per day – 5 days max $15 Copay	 90% $50 Copay
Drug/Substance Abuse In-Patient (Detox Only)	 $250 Copay per day – 5 days max	 90%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 See Plan Specific EOC [4] Not Covered Not Covered Not Covered Not Covered	 See Plan Specific EOC [4] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vison 100% 100% (in lieu of eyeglasses) 100% 1 pair per calendar year	 Oscar Davis Vision $50 Copay 90% (in lieu of eyeglasses) 90% 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Oscar Liberty None Combined with Medical Copay varies by service 100% [2] Copay varies by service Copay varies by service $1,000 Copay	 Oscar Liberty None Combined with Medical Copay varies by service 100% [2] Copay varies by service Copay Varies by service 90%

* *All services are subject to the deductible unless otherwise stated.
1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Maximum member responsibility.
4. Evaluation only.

Gold EPO

Groups Beginning 12/1/18

Services	EPO A	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Gold**	**Gold**	**Gold**
Calendar Year Deductible*	$500 / $1,000 (combined Med/ Pediatric dental ded)(applies to Max OOP)	None	$2,000 / $4,000 (combined Med/ Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$5,000 / $10,000	$6,000 / $12,000	$7,000 / $14,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Dr. Office Visits (PCP)	$25 Copay (ded waived)	$25 Copay	$10 Copay (ded waived)
Specialist Visit (SPC)	$50 Copay (ded waived)	$55 Copay	$50 Copay (ded waived)
Laboratory	$25 Copay (ded waived)	$35 Copay	80%
X-Ray	80%	$55 Copay	80%
MRI, CT and PET (office setting)	80%	$275 Copay	80%
Hospital Services – In-Patient	80%	$600 Copay per day – 5 days max	80%
In-Patient Physician Fees	80%	100%	80%
Emergency Room (copay waived if admitted)	$300 Copay (ded waived)	$325 Copay	$300 Copay (ded waived)
Urgent Care	$50 Copay (ded waived)	$25 Copay	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 $300 Copay $300 Copay	 80% 80%
Hospital Pre-Authorization	Required	Required	Required
2nd Surgical Opinion	$50 Copay (ded waived)	$55 Copay	$50 Copay (ded waived)
Ambulance Services (per trip)	$300 Copay (ded waived)	$250 Copay	$300 Copay (ded waived)
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 $10 Copay (overall ded waived) $50 Copay (overall ded waived) $75 Copay (overall ded waived) 80% (overall ded waived)	 $15 Copay $55 Copay $75 Copay 80% (up to $250 per prescription[3])	 $10 Copay (overall ded waived) $50 Copay (overall ded waived) $75 Copay (overall ded waived) 80% (overall ded waived)
Oral Contraceptives	100% (ded waived)	100%	100% (ded waived)
Diabetes – Self-Injectable	Applicable Rx Copay (overall ded waived)	Applicable Rx Copay	Applicable Rx Copay (overall ded waived)
Pre-Existing Conditions	Covered	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)[1]	100%[1]	100% (ded waived)[1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness	Covered as any Illness
Chemotherapy	80%	80%	80%
Chiropractic (20 visits max per year)	Not Covered	Not Covered	Not Covered
Acupuncture	$25 Copay (ded waived)	$25 Copay	$10 Copay (ded waived)
Physical, Occupational, Speech Therapy	$25 Copay (ded waived)	$25 Copay	$25 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	$25 Copay (ded waived)	$25 Copay	$25 Copay (ded waived)
Home Health Care (Max 100 visits per year)	$50 Copay (ded waived)	$30 Copay	$50 Copay (ded waived)

Gold EPO

Groups Beginning 12/1/18

Services	EPO A	EPO B	EPO C
Participating Health Plans	Oscar	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO	Oscar EPO
Metal Tier	**Gold**	**Gold**	**Gold**
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	$300 Copay per day – 5 days max	80%
Hospice	$25 Copay (ded waived)	100%	$10 Copay (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80%	80%	80%
Mental Health In-Patient Out-Patient (office visit)	 80% $50 Copay (ded waived)	 $600 Copay per day – 5 days max $25 Copay	 80% $50 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 $600 Copay per day – 5 days max	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 See Plan Specific EOC [4] Not Covered Not Covered Not Covered Not Covered	 See Plan Specific EOC [4] Not Covered Not Covered Not Covered Not Covered	 See Plan Specific EOC [4] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision $50 Copay (ded waived) 80% (in lieu of eyeglasses) 80% 1 pair per calendar year	 Oscar Davis Vision 100% 100% (in lieu of eyeglasses) 100% 1 pair per calendar year	 Oscar Davis Vision $50 Copay (ded waived) 80% (in lieu of eyeglasses) 80% 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Oscar Liberty Combined Med/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service 80%	 Oscar Liberty None Combined with Medical Copay varies by service 100% [2] Copay varies by service Copay varies by service $1,000 Copay	 Oscar Liberty Combined Med/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service 80%

* All services are subject to the deductible unless otherwise stated.
1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Maximum member responsibility.
4. Evaluation only.

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Silver EPO

Groups Beginning 12/1/18

Services	EPO A† (HSA Qualified)	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Silver**	**Silver**
Calendar Year Deductible*	$2,000 / $2,700 / $4,000 [3] (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$2,000 / $4,000 (combined Med/ Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,550 / $13,100	$7,000 / $14,000
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	80%	$45 Copay (ded waived)
Specialist Visit (SPC)	80%	$75 Copay (ded waived)
Laboratory	80%	$40 Copay (ded waived)
X-Ray	80%	$70 Copay (ded waived)
MRI, CT and PET (office setting)	80%	$300 Copay (ded waived)
Hospital Services – In-Patient	80%	80%
In-Patient Physician Fees	80%	80%
Emergency Room (copay waived if admitted)	80%	$350 Copay (ded waived)
Urgent Care	80%	$45 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 80% 80%	 80% (ded waived) 80% (ded waived)
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	80%	$75 Copay (ded waived)
Ambulance Services (per trip)	80%	$250 Copay
Rx Benefits		
Generic	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$125 / $250 Ded - $15 Copay
Formulary Brand	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$125 / $250 Ded - $55 Copay
Non-Formulary Brand	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$125 / $250 Ded - $85 Copay
Specialty	80% (up to $250 per prescription [4]) (combined Med/Rx/Pediatric dental ded)	$125 / $250 Ded – 80% (up to $250 per prescription [4])
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded/Rx Copay	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived)	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	80%	80% (ded waived)
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	80%	$45 Copay (ded waived)
Physical, Occupational, Speech Therapy	80%	$45 Copay (ded waived)
Rehabilitative & Habilitative Services and Devices	80%	$45 Copay (ded waived)

Services	EPO A† HSA Qualified	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Gold**	**Silver**
Home Health Care (Max 100 visits per year)	80%	$45 Copay (ded waived)
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	80%	80%
Hospice	100%	100% (ded waived)
Durable Medical Equipment (Covered when medically necessary)	80%	80% (ded waived)
Mental Health In-Patient Out-Patient (office visit)	 80% 80%	 80% $45 Copay (ded waived)
Drug/Substance Abuse In-Patient (Detox Only)	 80%	 80%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 See Plan Specific EOC [5] Not Covered Not Covered Not Covered Not Covered	 See Plan Specific EOC [5] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision 100% (ded waived) 100% (ded waived)(in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year	 Oscar Davis Vision 100% (ded waived) 100% (ded waived)(in lieu of eyeglasses) 100% (ded waived) 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service 50% (ded waived)	 Oscar Liberty Combined Med/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service $1,000 Copay (ded waived)

† HSA Qualified High Deductible Plan

* All services are subject to the deductible unless otherwise stated.

1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Individual with self-only coverage amount / Individual with family coverage amount / Family coverage amount.
4. Maximum member responsibility.
5. Evaluation only.

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Bronze EPO

Groups Beginning 12/1/18

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**
Calendar Year Deductible*	$6,500 / $13,000 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)	$7,350 / $14,700 (combined Med/Rx/Pediatric dental ded)(applies to Max OOP)
Out-of-Pocket Max Ind/Fam	$6,500 / $13,000	$7,350 / $14,700
Lifetime Maximum	Unlimited	Unlimited
Dr. Office Visits (PCP)	100%	100%
Specialist Visit (SPC)	100%	100%
Laboratory	100%	100%
X-Ray	100%	100%
MRI, CT and PET (office setting)	100%	100%
Hospital Services – In-Patient	100%	100%
In-Patient Physician Fees	100%	100%
Emergency Room (copay waived if admitted)	100%	100%
Urgent Care	100%	$50 Copay (ded waived)
Hospital Services – Out-Patient Surgical Facility Ambulatory Surgery Center	 100% 100%	 100% 100%
Hospital Pre-Authorization	Required	Required
2nd Surgical Opinion	100%	100%
Ambulance Services (per trip)	100%	100%
Rx Benefits Generic Formulary Brand Non-Formulary Brand Specialty	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)	 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded) 100% (combined Med/Rx/Pediatric dental ded)
Oral Contraceptives	100% (ded waived)	100% (ded waived)
Diabetes – Self-Injectable	Applicable Ded/Rx Copay	Applicable Ded/Rx Copay
Pre-Existing Conditions	Covered	Covered
Maternity and Newborn Care	Covered as any Illness	Covered as any Illness
Preventive/Wellness Services	100% (ded waived) [1]	100% (ded waived) [1]
Chronic Disease Management	Covered as any Illness	Covered as any Illness
Chemotherapy	100%	100%
Chiropractic (20 visits max per year)	Not Covered	Not Covered
Acupuncture	100%	100%
Physical, Occupational, Speech Therapy	100%	100%
Rehabilitative & Habilitative Services and Devices	100%	100%

Services	EPO A	EPO B
Participating Health Plans	Oscar	Oscar
Network Name	Oscar EPO	Oscar EPO
Metal Tier	**Bronze**	**Bronze**
Home Health Care (Max 100 visits per year)	100%	100%
Skilled Nursing Facility Per Disability (Max 100 days per benefit period)	100%	100%
Hospice	100%	100%
Durable Medical Equipment (Covered when medically necessary)	100%	100%
Mental Health In-Patient Out-Patient (office visit)	 100% 100%	 100% 100%
Drug/Substance Abuse In-Patient (Detox Only)	 100%	 100%
Infertility Infertility Evaluation and Treatment Infertility Drugs In Vitro Fertilization (IVF) Gamete Intrafallopian Transfer (GIFT) Zygote Intrafallopian Transfer (ZIFT)	 See Plan Specific EOC [3] Not Covered Not Covered Not Covered Not Covered	 See Plan Specific EOC [3] Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Carrier Network Exam Contact Lenses Frames Maximum Allowance per year	 Oscar Davis Vision 100% 100% (in lieu of eyeglasses) 100% 1 pair per calendar year	 Oscar Davis Vision 100% 100% (in lieu of eyeglasses) 100% 1 pair per calendar year
Pediatric Dental Carrier Network Deductible Out-of-Pocket Maximum Office Visit Diagnostic & Preventative (D&P) Basic Services Major Services (no waiting period) Orthodontics (medically necessary)	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service 100%	 Oscar Liberty Combined Med/Rx/Pediatric dental ded Combined with Medical Copay varies by service 100% (ded waived) [2] Copay varies by service Copay varies by service 100%

* All services are subject to the deductible unless otherwise stated.

1. See plan specific EOC for information on preventive services.
2. Preventive is covered in full, please see plan specific EOC for information on Diagnostic cost shares.
3. Evaluation only.

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