2023 Plan Summary
Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Platinum (90%)	•Blue Shield 0/15(PPO) •Sharp 0/15 (Performance HMO)	(OON) = Out of Network •Blue Shield 0/15 (OON)	•Kaiser 0/20 (HMO) •Blue Shield 0/20 (Trio HMO) •Blue Shield 0/20 (Access+ HMO) New Plan Q3 2023 •Sharp 0/20 (Premier HMO)	•Kaiser 0/10 Alt (HMO)
Service Type	In-Network	Out-of- Network	In-Network	In-Network
Individual Deductible (if any)	$0	$1,000	$0	$0
Family Deductible (if any)	$0	$2,000	$0	$0
Preventive Care/ Screening/Immunization	No Charge	Not Covered	No Charge	No Charge
Primary Care Visit to treat an injury, illness, or Condition	$15	50% Coinsurance after deductible	$20	$10
Other Practitioner Office Visit	$15	50% Coinsurance after deductible	$20	$10
Specialist Visit	$30	50% Coinsurance after deductible	$30	$20
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge
Urgent Care	$15	50% Coinsurance after deductible	$20	$10
Laboratory Tests	$15	50% Coinsurance after deductible	$20	$20
X-Ray and Diagnostic Imaging	$30	50% Coinsurance after deductible	$30	$40
Emergency Room Facility Fee (waived if admitted)	$200	$200	$150	$200
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge
Emergency medical transportation	$150	$150	$150	$150
Outpatient Surgery Facility Fee (e.g.,ASC)	10%	50% Coinsurance subject to benefit maximum of $350/day after deductible	$100 Kaiser: $125	$300
Outpatient Physician/Surgeon Fee	10%	50% Coinsurance after deductible	$25 Kaiser: No Charge	No Charge
Outpatient Visit	10%	50% Coinsurance subject to benefit maximum of $350/day after deductible	10%	No Charge
Inpatient Physician/Surgeon Fee	10%	50% Coinsurance after deductible	No Charge	No Charge
Inpatient Facility Fee (e.g. hospital room)	10%	50% Coinsurance subject to benefit maximum of $2000/day after deductible	$250 Copay per day (up to 5 days)	$500 Copay per admission
Durable Medical Equipment	10%	50% Coinsurance after deductible	10%	10%
Imaging (CT/PET scans, MRIs)	10%	50% Coinsurance subject to benefit maximum of $350/day after deductible	$100	$150
Tier 1 (Generic Drugs)	$10	Not Covered	$5 Blue Shield Trio: Level A $5, Level B $7	$5
Tier 2 (Preferred Brand Drugs)	$25	Not Covered	$20 Blue Shield Trio: Level A $20, Level B $35	$15
Tier 3 (Nonpreferred Brand Drugs)	$40	Not Covered	$30 Kaiser: $20 Blue Shield Trio: Level A $30, Level B $50	$15
Tier 4 (Specialty Drugs)	10% (up to $250 per script)	Not Covered	10% (up to $250 per script)	10% (up to $250 per script)
Mental/Behavior Health Outpatient Office Visits	$15	50% Coinsurance after deductible	$20	$10
Mental/Behavior Health Inpatient Physician Fee	10%	50% Coinsurance after deductible	No Charge	No Charge
Mental/Behavior Health Inpatient Facility Fee	10%	50% Coinsurance subject to benefit maximum of $2000/day after deductible	$250 Copay per day (up to 5 days)	$500 Copay per admission
Substance Use Disorder Outpatient Office Visits	$15	50% Coinsurance after deductible	$20	$10
Substance Use Inpatient Physician Fee	10%	50% Coinsurance after deductible	No Charge	No Charge
Substance Use Inpatient Facility Fee (e.g. hospital room)	10%	50% Coinsurance subject to benefit maximum of $2000/day after deductible	$250 Copay per day (up to 5 days)	$500 Copay per admission
Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Sharp, Blue Shield: Pediatric Dental Embedded Kaiser: Bundled	Bundled
MAXIMUM OUT-OF-POCKET FOR ONE	$4,500	Blue Shield: $9,000	$4,500	$3,000
MAXIMUM OUT-OF-POCKET FOR FAMILY	$9,000	Blue Shield: $18,000	$9,000	$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 by selecting the applicable carrier at www.coveredca.com/forsmallbusiness/plans/ or requested from the Covered California for Small Business Customer Service Center at 855-777-6782.

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. In-network 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 2023 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