COVERED CALIFORNIA SMALL BUSINESS

2023 Plan Summary
Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Gold (80%)	•Blue Shield 350/25 (PPO) •Sharp 350/25 (Performance HMO)	(OON) = Out of Network Blue Shield 350/25 (OON)	•Kaiser 250/35 (HMO) •Blue Shield 250/35 (Trio HMO) •Blue Shield 250/35 (Access HMO) New Plan Q3 2023 •Sharp 250/35 (Premier HMO)	Kaiser 0/30 Alt (HMO)	Kaiser Gold 1000/40 Alt (HMO)	Kaiser Gold HDHP 1600/15% ALT (HMO)
Service Type	In-Network	Out-of-Network	In-Network	In-Network	In-Network	In-Network
Individual Deductible (if any)	$350	$1,000	$250	$0	$1,000/$250 Pharmacy	$1,600
Family Deductible (if any)	$700	$2,000	$500	$0	$2,000/$500 Pharmacy	$3,200
Preventive Care/Screening/ Immunization	No Charge	Not Covered	No Charge	No Charge	No Charge	No Charge
Primary Care Visit to treat an injury, illness or condition	$25	50% Coinsurance after deductible	$35	$30	$40	15% Coinsurance after deductible
Other Practitioner Office Visit	$25	50% Coinsurance after deductible	$35	$30	$40	15% Coinsurance after deductible
Specialist Visit	$50	50% Coinsurance after deductible	$55	$50	$60	15% Coinsurance after deductible
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge
Urgent Care	$25	50% Coinsurance after deductible	$35	$30	$40	15% Coinsurance after deductible
Laboratory Tests	$25	50% Coinsurance after deductible	$35	$30	$30	15% Coinsurance after deductible
X-Rays and Diagnostic Imaging	$65	50% Coinsurance after deductible	$55	$40	$60	15% Coinsurance after deductible
Emergency Room Facility Fee (waived if admitted)	20% Coinsurance after deductible	20% Coinsurance after deductible	$250 Copay after deductible	$250	$350	15% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	No Charge	No Charge	No Charge	No Charge	No Charge	15% Coinsurance after deductible
Emergency Medical Transportation	20% Coinsurance after deductible	20% Coinsurance after deductible	$250 Copay after deductible	$250	$350	15% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	20%	50% Coinsurance subject to benefit maximum of $350/day after deductible	$300 Copay after deductible Kaiser: $335 Copay after deductible	$320	$350	15% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	20%	50% Coinsurance after deductible	$35 Copay Kaiser: No Charge	No Charge	No Charge	15% Coinsurance after deductible
Outpatient Visit	20%	50% Coinsurance subject to benefit maximum of $350/day after deductible	20%	No Charge	No Charge	15% Coinsurance after deductible
Inpatient Physician/ Surgeon Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	No Charge	No Charge	No Charge	15% Coinsurance after deductible
Inpatient Facility Fee (e.g. hospital room)	20% Coinsurance after deductible	50% Coinsurance subject to benefit maximum of $2000/day after deductible	$600 / day (up to 5 days) after deductible	$600 / day (up to 5 days)	$600 / day (up to 5 days) after deductible	15% Coinsurance after deductible
Durable Medical Equipment	20%	50% Coinsurance after deductible	20%	20%	20%	15% Coinsurance after deductible
Imaging (CT/PET scans, MRIs)	20%	50% Coinsurance subject to benefit maximum of $350/day after deductible	$250 Copay after deductible	$250	$350 Copay after deductible	15% Coinsurance after deductible
Tier 1 (Generic Drugs)	$15	Not Covered	$15 Blue Shield Trio: Level A $15, Level B $20	$15	$20	$15 Copay after pharmacy deductible
Tier 2 (Preferred Brand Drugs)	$50	Not Covered	$40 Blue Shield Trio: Level A $40, Level B $60	$50	$50 after pharmacy deductible	$45 Copay after pharmacy deductible
Tier 3 (Nonpreferred Brand Drugs)	$80	Not Covered	$70 Kaiser: $40 Blue Shield Trio: Level A $70, Level B $100	$50	$50 after pharmacy deductible	$45 Copay after pharmacy deductible
Tier 4 (Specialty Drugs)	20% (up to $250 / script)	Not Covered	20% (up to $250 / script)	20% (up to $250/script)	20% Coinsurance after pharmacy deductible (up to $250 / script)	15% Coinsurance after pharmacy deductible (Up to $250/script)
Mental/Behavior Health Outpatient Office Visits	$25	50% Coinsurance after deductible	$35	$30	$40	15% Coinsurance after deductible
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	No Charge	No Charge	No Charge	15% Coinsurance after deductible
Mental/Behavior Health Inpatient Facility Fee	20% Coinsurance after deductible	50% Coinsurance subject to benefit maximum of $2000/day after deductible	$600 / day (up to 5 days) after deductible	$600 / day (up to 5 days)	$600 / day (up to 5 days) after deductible	15% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	$25	50% Coinsurance after deductible	$35	$30	$40	15% Coinsurance after deductible
Substance Use Inpatient Physician Fee	20% Coinsurance after deductible	50% Coinsurance after deductible	No Charge	No Charge	No Charge	15% Coinsurance after deductible
Substance Use Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible	50% Coinsurance subject to benefit maximum of $2000/day after deductible	$600 / day (up to 5 days) after deductible	$600 / day (up to 5 days)	$600 / day (up to 5 days) after deductible	15% Coinsurance after deductible
Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Blue Shield: Pediatric Dental Embedded Kaiser: Bundled	Bundled	Bundled	Bundled
MAXIMUM OUT-OF-POCKET FOR ONE	**$7,800**	**Blue Shield: $12,850**	**$7,800**	**$7,500**	**$7,800**	**$3,550**
MAXIMUM OUT-OF-POCKET FOR FAMILY	**$15,600**	**Blue Shield: $25,700**	**$15,600**	**$15,000**	**$15,600**	**$7,100**

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 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.