



2027 Plan Summary
Covered California for Small Business

Light Shading indicates benefit changed from prior year

Bronze (60%)	5800/60 PCP Blue Shield (PPO) Sharp (Performance HMO)	(OON) = Out of Network Blue Shield \$800/60 PCP (OON)	Blue Shield 7000/65 PCP Alt (HMO)	Blue Shield HDHP PPO 7850/0%PCP Alt	(OON) = Out of Network BlueShieldHDHP PPO PCP 7850/0% PCP-A	5800/60 PCP HMO Kaiser Western Health Advantage	7800/0% PCP Kaiser HDHP (HMO) Sharp HDHP (Premier HMO)
Service Type	In-Network	Out-of-Network	In-Network	In-Network	Out-of-Network	In-Network	In-Network
Individual Deductible (if any)	\$5,800/Medical/\$450 Pharmacy (All Carriers)	BlueSHld: \$2,500 Medical	\$7,000 Medical and Pharmacy Combined	\$7,850 Medical and Pharmacy Combined	\$25,700 Medical and Pharmacy Combined	\$5,800 Medical/\$450 Pharmacy (All Carriers)	\$7,800 (All Carriers)
Family Deductible (if any)	\$11,600/Medical/\$900 Pharmacy (All Carriers)	BlueSHld: \$2,500 Medical	\$14,000 Medical and Pharmacy Combined	\$15,700 Medical and Pharmacy Combined	\$31,400 Medical and Pharmacy Combined	\$11,600 Medical/\$900 Pharmacy (All Carriers)	\$15,600 (All Carriers)
Preventive Care/Screening/Immunization	\$0 (All Carriers)	Not Covered	\$0	\$0	Not Covered	\$0 (All Carriers)	\$0 (All Carriers)
Primary Care visit for treatment, illness or condition	\$60 (All Carriers)	50% Coinsurance after deductible	\$60	\$0 after deductible	10% Coinsurance after deductible	\$60 copay (All Carriers)	0% Coinsurance after deductible (All Carriers)
Other Practitioner Office Visit	\$60 (All Carriers)	50% Coinsurance after deductible	\$60	\$0 after deductible	10% Coinsurance after deductible	\$60 copay (All Carriers)	0% Coinsurance after deductible (All Carriers)
Specialist visit	\$100 Copay after deductible* (All Carriers)	50% Coinsurance after deductible	\$80	\$0 after deductible	10% Coinsurance after deductible	\$100 Copay after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Perinatal Care and Postpartum on Vist	\$0 (All Carriers)	50% Coinsurance after deductible	\$0	\$0	10% Coinsurance after deductible	\$0 (All Carriers)	\$0 (All Carriers)
Urgent Care	\$60 (All Carriers)	50% Coinsurance after deductible	\$60	\$0 after deductible	10% Coinsurance after deductible	\$60 Copay All Carriers	0% Coinsurance after deductible (All Carriers)
Laboratory Tests	\$50 (All Carriers)	50% Coinsurance after deductible	\$60	\$0 after deductible	10% Coinsurance after deductible	\$50 (All Carriers)	0% Coinsurance after deductible (All Carriers)
X-Ray and Diagnostic Imaging	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$15 after deductible	\$0 after deductible	10% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Emergency Room Facility Fee (admitted if admitted)	40% Coinsurance after deductible (All Carriers)	40% Coinsurance after deductible	50% Coinsurance after deductible	\$0 after deductible	\$0 after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Emergency Room Physician Fee (admitted if admitted)	\$0 (All Carriers)	Not Covered	50% Coinsurance after deductible	\$0 after deductible	\$0 after deductible	\$0 (All Carriers)	0% Coinsurance after deductible (All Carriers)
Emergency Medical Transportation	40% Coinsurance after deductible (All Carriers)	40% Coinsurance after deductible	50% Coinsurance after deductible	\$0 after deductible	\$0 after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Outpatient Surgery Facility Fee (e.g., ASC)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50% Coinsurance after deductible	\$0 after deductible	10% Coinsurance after deductible up to \$500/day after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Outpatient Physician/Surgeon Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$50	\$0 after deductible	10% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Outpatient Visit	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50% Coinsurance after deductible	\$0 after deductible	10% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Inpatient Physician/Surgeon Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50% Coinsurance	\$0 after deductible	10% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Inpatient Facility Fee (e.g., Hospital room)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50% Coinsurance after deductible	\$0 after deductible	10% Coinsurance after deductible up to \$200 per day after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Durable Medical Equipment	40% Coinsurance after deductible (All Carriers)	Not Covered	50% Coinsurance	\$0 after deductible	Not Covered Deductibles do not apply	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Imaging (CT/PET scans, MRIs)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$400 Copayment after deductible	\$0 after deductible	10% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Tier 1 (Generic Drugs)	Blue Shield: Level A: \$20 Level B: 15% after deductible \$20 (All other Carriers)	Not Covered	Level A: \$25 Level B: \$30	Level A: \$0 after deductible Level B: 10% after deductible	Not Covered	\$20 (All Carriers)	0% Coinsurance after deductible (All Carriers)
Tier 2 (Preferred Brand Drugs)	40% up to \$500 per outpatient pharmacy deductible (All Carriers) including Level B, for BlueShield	Not Covered	Level A: \$115 after deductible Level B: \$145 after deductible	Level A: \$0 after deductible Level B: 10% after deductible	Not Covered	40% up to \$500 per script after pharmacy deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Tier 3 (Nonpreferred Brand Drugs)	40% up to \$500 per outpatient pharmacy deductible (All Carriers) including Level B, for BlueShield	Not Covered	Level A: \$160 after deductible Level B: \$210 after deductible	Level A: \$0 after deductible Level B: 10% after deductible	Not Covered	40% up to \$500 per script after pharmacy deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Tier 4 (Specialty Drugs)	40% up to \$500 per script after pharmacy deductible (All Carriers) including Level B, for BlueShield	Not Covered	Level A and B: 50% Coinsurance up to \$500 Prescription after deductible	Level A: \$0 after deductible Level B: 10% after deductible	Not Covered	40% up to \$500 per script after pharmacy deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Mental/Behavioral Health Outpatient Office Visit	\$60 (All Carriers)	50% Coinsurance after deductible	\$60	\$0 after deductible	50% Coinsurance after deductible	\$0 Kaiser \$60 Western Health Advantage	0% Coinsurance after deductible (All Carriers)
Mental/Behavioral Health Inpatient Physician Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50%	\$0 after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Mental/Behavioral Health Inpatient Facility Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50% Coinsurance after deductible	\$0 after deductible	10% Coinsurance after deductible up to \$200 per day after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Substance Use Disorder Outpatient Office Visit	\$60 (All Carriers)	50% Coinsurance after deductible	\$60	\$0 after deductible	50% Coinsurance after deductible	\$0 Kaiser \$60 Western Health Advantage	0% Coinsurance after deductible (All Carriers)
Substance Use Inpatient Physician Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50%	\$0 after deductible	50% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Substance Use Inpatient Facility Fee (In-patient room)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	50% Coinsurance after deductible	\$0 after deductible	10% Coinsurance after deductible up to \$200 per day after deductible	40% Coinsurance after deductible (All Carriers)	0% Coinsurance after deductible (All Carriers)
Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Western Health Advantage Pediatric Dental Embedded Kaiser-Bundled	Sharp Embedded Kaiser-Bundled
MAXIMUM OUT-OF-POCKET FOR ONE	\$11,650 (All Carriers)	Blue Shield: \$23,300	\$11,660	\$7,830	\$15,700	\$11,660	\$7,800 (All Carriers)
MAXIMUM OUT-OF-POCKET FOR FAMILY	\$23,300 (All Carriers)	Blue Shield: \$46,600	\$23,300	\$15,700	\$31,400	\$23,300	\$15,600 (All Carriers)

Please Note: This document does not supersede the Carrier's Evidence of Coverage (EOC) documents, which can be viewed online at www.coveredca.com or requested from the Covered California Small Business Customer Service Center at 855-777-4782. Notes

[1] Any and all cost sharing payments for in-network covered services apply to the **in-network** benefit and maximum. If a deductible applies to the **in-network** services, cost sharing payments for all in-network services accumulate toward the **in-network** 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 all except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible requirement 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, matches the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by that HDHP's evidence of coverage for the 2027 calendar year for its Rating Adjusted Amount for Health Savings Accounts (HSA). Issued pursuant to section 23 of this term of the use 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.