

	2027 Plan Summary Covered California for Small Business							Light Shading indicates plan change from prior year
Gold (80%)	Blue Shield 500 /30 PCP (PPO) Sharp 500 /30 PCP (Performance HMO)	(OON) = Out of Network Blue Shield 500/30 PCP (OON)	Blue Shield 325/40 PCP (Trio HMO, Access+) Sharp 325/40PCP (Premier HMO) Kaiser 325/40 (HMO) Western Health Advantage 325/40 PCP (HMO)	Kaiser 0/50 PCP Alt (HMO)	Kaiser 1000/45 PCP Alt (HMO) (HMO)	Kaiser HDHP 2000/15% ALT PCP (HMO)	Kaiser 500/35 PCP ALT (HMO)	Western Health Advantage 1000/40 PCP Alt (HMO)
Service Type	In-Network	Out-of-Network	In-Network	In-Network	In-Network	In-Network	In-Network	
Individual Deductible (if any)	\$500 (All Carriers)	\$2,000	\$325 (All Carriers)	\$0	\$1,000/\$250 Pharmacy	\$2,000	\$900	\$1,000 Medical/\$500 Pharmacy
Family Deductible (if any)	\$1000 (All Carriers)	\$4,000	\$600 (All Carriers)	\$0	\$2,000/\$500 Pharmacy	\$4,000	\$1,000	\$2,000 Medical/\$1000 Pharmacy
Preventive Care/Screening/Immunization	\$0 (All Carriers)	Not Covered	\$0 (All Carriers)	\$0	\$0	\$0	\$0	\$0
Primary Care Visit/treat an injury, illness or condition	\$30 (All Carriers)	50% Coinsurance after deductible	\$40 (All Carriers)	\$50	\$45	15% Coinsurance after deductible	\$35	\$40
Other Practitioner Office Visit	\$30 (All Carriers)	50% Coinsurance after deductible	\$40 (All Carriers)	\$50	\$45	15% Coinsurance after deductible	\$35	\$40
Specialist Visit	\$60 (All Carriers)	50% Coinsurance after deductible	\$60 (All Carriers)	\$85	\$60	15% Coinsurance after deductible	\$70	\$60
Prenatal Care and Preconception Visit	\$0 (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	\$0	\$0	\$0
Urgent Care	\$30 (All Carriers)	50% Coinsurance after deductible	\$40 (All Carriers)	\$50	\$45	15% Coinsurance after deductible	\$35	\$50
Laboratory Tests	\$25 (All Carriers)	50% Coinsurance after deductible	\$40 (All Carriers)	\$30	\$35	15% Coinsurance after deductible	\$35	\$0
X-Rays and Diagnostic Imaging	\$65 (All Carriers)	50% Coinsurance after deductible	\$60 (All Carriers)	\$60	\$60	15% Coinsurance after deductible	\$60	\$40
Emergency Room/Facility Fee (waived if admitted)	20% Coinsurance after deductible (All Carriers)	20% Coinsurance after deductible	\$300 Copay after deductible (All Carriers)	\$350	\$350	15% Coinsurance after deductible	\$350	\$300 Copay after deductible
Emergency Room Physician Fee (waived if admitted)	\$0 (All Carriers)	\$0	\$0 (All Carriers)	\$0	\$0	15% Coinsurance after deductible	\$0	\$0
Emergency Medical Transportation	20% Coinsurance after deductible (All Carriers)	20% Coinsurance after deductible	\$250 Copay after deductible (All Carriers)	\$250	\$350	15% Coinsurance after deductible	\$350	\$0
Outpatient Surgery Facility Fee (e.g., ASC)	20% (All Carriers)	50% Coinsurance after deductible	Kaiser: \$300 \$300 Copay after deductible (All Other Carriers)	\$400	\$400 Copay after deductible	15% Coinsurance after deductible	\$400 Copay after deductible	\$500 Copay after deductible
Outpatient Physician/ Surgeon Fee	20% (All Carriers)	50% Coinsurance after deductible	Kaiser: \$0 \$50 (All Other Carriers)	\$0	\$0	15% Coinsurance after deductible	\$0 Copay after deductible	\$0
Outpatient Visit	20% (All Carriers)	50% Coinsurance after deductible	20% (All Carriers)	\$0	\$0	15% Coinsurance after deductible	20%	\$0
Inpatient Physician/ Surgeon Fee	20% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	15% Coinsurance after deductible	\$0	\$0
Inpatient Facility Fee (e.g. hospital room)	20% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$600/Day (upto 5 days) after deductible (All Carriers)	\$600/Day (upto 5 days)	\$600/Day (upto 5 days) after deductible	15% Coinsurance after deductible	\$600 Copay per Day (upto 5 days) after deductible	\$500/Day (upto 5 days) after deductible
Durable Medical Equipment	20% (All Carriers)	50% Coinsurance after deductible	20% (All Carriers)	20%	20%	15% Coinsurance after deductible	20%	20%
Imaging (CT/PET scans, MRI)	20% (All Carriers)	50% Coinsurance after deductible	\$350 Copay after deductible (All Carriers)	\$250	\$350	15% Coinsurance after deductible	\$350	\$300
Tier 1 (Generic Drugs)	Blue Shield Level A: \$20, Level B: \$25 Sharp \$20	Not Covered	Blue Shield Level A: \$15, Level B: \$20 \$15 (All other Carriers)	\$15	\$15	\$15 Copay after deductible	\$15	\$10
Tier 2 (Preferred Brand Drugs)	Blue Shield Level A: \$50, Level B: \$70 Sharp \$50	Not Covered	Blue Shield Level A: \$50, Level B: \$70 \$50 (All other Carriers)	\$90	\$50 after pharmacy deductible	\$45 Copay after deductible	\$90	\$50 after pharmacy deductible
Tier 3 (Nonpreferred Brand Drugs)	Blue Shield Level A: \$80, Level B: \$110 Sharp \$80	Not Covered	Blue Shield Level A: \$70, Level B: \$100 Kaiser: \$50 \$20 (All other Carriers)	\$50	\$50 after pharmacy deductible	\$45 Copay after deductible	\$50	\$75 after pharmacy deductible
Tier 4 (Specialty Drugs)	Blue Shield Level A: 20%, Level B: 20% up to \$250 per script after deductible Sharp: 20% (Up to \$250/script)	Not Covered	Blue Shield Level A: 20%, Level B: 20% up to \$250 per script after deductible 20% (Up to \$250/script) (All other Carriers)	20% (Up to \$250/script)	20% Coinsurance after pharmacy deductible (Up to \$250/script)	15% Coinsurance after deductible (Up to \$250/script)	20% Coinsurance (Up to \$250/script)	20% Coinsurance after deductible (Up to \$250/script)
Mental/Behavior Health Outpatient Office Visits	\$30 (All Carriers)	50% Coinsurance after deductible	Kaiser: \$0 \$40 (All Other Carriers)	\$0	\$0	15% Coinsurance after deductible	\$0	\$40
Mental/Behavior Health Inpatient Physician Fee	20% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	15% Coinsurance after deductible	\$0	\$0
Mental/Behavior Health Inpatient Facility Fee	20% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$600/Day (upto 5 days) after deductible (All Carriers)	\$600/Day (upto 5 days)	\$600/Day (upto 5 days) after deductible	15% Coinsurance after deductible	\$600 Copay per Day (upto 5 days) after deductible	\$500/Day (upto 5 days) after deductible
Substance Use Disorder Outpatient Office Visits	\$30 (All Carriers)	50% Coinsurance after deductible	Kaiser: \$0 \$40 (All Other Carriers)	\$0	\$0	15% Coinsurance after deductible	\$0	\$40
Substance Use Inpatient Physician Fee	20% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	15% Coinsurance after deductible	\$0	\$0
Substance Use Inpatient Facility Fee (e.g., hospital room)	20% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	\$600/Day (upto 5 days) after deductible (All Carriers)	\$600/Day (upto 5 days)	\$600/Day (upto 5 days) after deductible	15% Coinsurance after deductible	\$600 Copay per Day (upto 5 days) after deductible	\$500/Day (upto 5 days) after deductible
Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Kaiser: Bundled Pediatric Dental Embedded (All other Carriers)	Bundled	Bundled	Bundled	Bundled	Pediatric Dental Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	\$8,600 (All Carriers)	\$17,200	\$8,600 (All Carriers)	\$9,500	\$9,500	\$5,000	\$9,500	\$8,500
MAXIMUM OUT-OF-POCKET FOR FAMILY	\$17,200 (All Carriers)	\$34,400	\$17,200 (All Carriers)	\$19,000	\$19,000	\$10,000	\$19,000	\$17,000

Please Note This document does not supersede the carriers' Evidence of Coverage (EOC) documents, which can be viewed on-line at www.coveredca.com 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 in-network out-of-pocket maximum. If a deductible applies to the in-network service, 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 plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual's 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 2027 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.