



COVERED CALIFORNIA
SMALL BUSINESS

2027 Plan Summary

Covered California for Small Business

Light Shading indicates benefit changed from prior year

Platinum (90%)	Blue Shield 0/25 PCP (PPO) Sharp 0/25 PCP (Performance HMO)	(OON) = Out of Network Blue Shield 0/15 PCP (OON)	Kaiser PCP 0/25 PCP (HMO) Blue Shield 0/25 PCP (Trio HMO, Access +) Sharp 0/25 PCP (Premier HMO) Western Health Advantage 0/25 PCP (HMO)	Kaiser 0/10 PCP Alt (HMO)	Kaiser 250/35 PCP Alt (HMO)	Western Health Advantage 0/20 PCP Alt (HMO)
Service Type	In-Network	Out-of-Network	In-Network	In-Network	In-Network	
Individual Deductible (if any)	\$0 (All Carriers)	\$2,000	\$0 (All Carriers)	\$0	\$250	\$0
Family Deductible (if any)	\$0 (All Carriers)	\$4,000	\$0 (All Carriers)	\$0	\$500	\$0
Preventive Care/Screening/Immunization	\$0 (All Carriers)	Not Covered	\$0 (All Carriers)	\$0	\$0	\$0
Primary Care Visit to treat an injury, illness or condition	\$25 (All Carriers)	50% Coinsurance after deductible	\$25 (All Carriers)	\$10	\$35	\$0
Other Practitioner Office Visit	\$25 (All Carriers)	50% Coinsurance after deductible	\$25 (All Carriers)	\$10	\$35	\$20
Specialist Visit	\$40 (All Carriers)	50% Coinsurance after deductible	\$40 (All Carriers)	\$30	\$55	\$20
Prenatal Care and Preconception Visit	\$0 (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	\$0
Urgent Care	\$25 (All Carriers)	50% Coinsurance after deductible	\$25 (All Carriers)	\$10	\$35	\$50
Laboratory Tests	\$25 (All Carriers)	50% Coinsurance after deductible	\$20 (All Carriers)	\$25	\$30	\$0
X-Rays and Diagnostic Imaging	\$45 (All Carriers)	50% Coinsurance after deductible	\$35 (All Carriers)	\$50	\$50	\$0
Emergency Room Facility Fee (waived if admitted)	\$250 (All Carriers)	\$250	\$250 (All Carriers)	\$200	\$250	\$300
Emergency Room Physician Fee (waived if admitted)	\$0 (All Carriers)	No Charge	\$0 (All Carriers)	\$0	\$0	\$0
Emergency Medical Transportation	\$150 (All Carriers)	\$150	\$150 (All Carriers)	\$150	\$150	\$0
Outpatient Surgery Facility Fee (eg., ASC)	10% (All Carriers)	50% Coinsurance after deductible	Kaiser: \$135 \$100 (All other Carriers)	\$400	\$400 Copay after deductible	\$300
Outpatient Physician/ Surgeon Fee	10% (All Carriers)	50% Coinsurance after deductible	Kaiser No Charge \$35 (All other Carriers)	\$0	\$0	\$0
Outpatient Visit	10% (All Carriers)	50% Coinsurance after deductible	10% (All Carriers)	\$0	\$0	\$0
Inpatient Physician/ Surgeon Fee	10% (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	\$0
Inpatient Facility Fee (eg. hospital room)	10% (All Carriers)	50% Coinsurance after deductible	\$300 Copay per day (up to 5 days) (All Carriers)	\$500 Copay per admit	\$500 Per Stay after deductible	30%
Durable Medical Equipment	10% (All Carriers)	50% Coinsurance after deductible	10% (All Carriers)	10%	10%	20%
Imaging (CT/PET scans, MRIs)	15% (All Carriers)	50% Coinsurance after deductible	\$150 (All Carriers)	\$150	\$150	\$300
Tier 1 (Generic Drugs)	\$10 (All Carriers)	Not Covered	Blue Shield Access + and Trio Level A: \$10 Blue Shield Trio: Level B \$15 \$10 (All other Carriers)	\$10	\$10	\$10
Tier 2 (Preferred Brand Drugs)	\$30 (All Carriers)	Not Covered	Blue Shield Access + and Trio Level A: \$25 Blue Shield Trio: Level B \$40 \$25 (All other Carriers)	\$20	\$20	\$40
Tier 3 (Nonpreferred Brand Drugs)	\$40 (All Carriers)	Not Covered	Blue Shield Access + and Trio Level A: \$40 Blue Shield Trio: Level B \$60 Kaiser: \$25 \$40 (All other Carriers)	\$20	\$20	\$60
Tier 4 (Specialty Drugs)	10% up to \$250 per script (All Carrier)	Not Covered	10% (up to \$250 per script) (All Carriers)	10%	10% Coinsurance after Deductible (up to \$250 per Script)	20% (up to \$250 per Script)
Mental/Behavior Health Outpatient Office Visits	\$25 (All Carriers)	50% Coinsurance after deductible	\$0 Kaiser \$25 (All other Carriers)	\$0	\$0	\$20
Mental/Behavior Health Inpatient Physician Fee	10% (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	\$0

Mental/Behavior Health Inpatient Facility Fee	10% (All Carriers)	50% Coinsurance after deductible	\$300 Copay per day (up to 5 days) (All Carriers)	\$500 Copay per admit	\$500 Per Stay after deductible	30%
Substance Use Disorder Outpatient Office Visits	\$25 (All Carriers)	50% Coinsurance after deductible	\$0 Kaiser \$25 (All other Carriers)	\$0	\$0	\$20
Substance Use Inpatient Physician Fee	10% (All Carriers)	50% Coinsurance after deductible	\$0 (All Carriers)	\$0	\$0	\$0
Substance Use Inpatient Facility Fee (e.g., hospital room)	10% (All Carriers)	50% Coinsurance after deductible	\$300 Copay per day (up to 5 days) (All Carriers)	\$500 Copay per admit	\$500 Per Stay after deductible	30%
Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Kaiser: Bundled All other Carriers: Embedded	Bundled	Bundled	Embedded
MAXIMUM OUT-OF-POCKET FOR ONE	\$5,000 (All Carriers)	Blue Shield: \$10,000	\$5,000 (All Carriers)	\$4,800	\$5,200	\$5,500
MAXIMUM OUT-OF-POCKET FOR FAMILY	\$10,000 (All Carriers)	Blue Shield: \$20,000	\$10,000 (All Carriers)	\$9,600	\$10,400	\$11,000

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 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.

