

2027 Plan Summary
Covered California for Small Business

Light shading indicates plan benefit change from prior year.

Silver (70%)	BlueShield 2500/60 PCP (PPO) Sharp 2500/60 PCP Performance (HMO)	BlueShield 2500/60 PCP (PPO) (OON) = Out of Network	BlueShield HDHP PPO 3430/30% PCP ALT	Kaiser 2500/60 PCP (HMO) Sharp 2500/60 PCP (Premier HMO) BlueShield 2500/60 PCP (Trio HMO, Access+) Western Health Advantage 2500/60 PCP (HMO)	Kaiser HDHP 3200/25% PCP(HMO) Sharp Premier HDHP 3200/25% PCP (HMO) Western Health Advantage HDHP 3200/25% PCP(HMO)	Kaiser 2000/65 HDHP Alt PCP (HMO)	Kaiser 2300/65 Alt PCP (HMO)	Kaiser 3400/75 Alt PCP (HMO)
	In-Network	Out of Network	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network
Individual Deductible (if any)	\$2,500/Medical/\$500/Pharmacy (All Carriers)	\$5,000	\$2,450 Medical and Pharmacy Combined	\$2,500/Medical/\$500/Pharmacy (All Carriers)	\$520 (All Carriers)	\$2,000	\$2,300 Medical/\$500 Pharmacy	\$3,400
Family Deductible (if any)	\$5,000/Medical/\$500/Pharmacy (All Carriers)	\$10,000	\$4,900 Medical and Pharmacy Combined	\$5,000 Medical/\$500 Pharmacy (All Carriers)	\$640 (All Carriers)	\$4,000	\$4,800 Medical/\$500 Pharmacy	\$6,800
Preventive Care/Screening/Vaccination	\$0 (All Carriers)	Not Covered	\$0	\$0 (All Carriers)	\$0 (All Carriers)	\$0	\$0	\$0
Primary Care Visit/treat an injury, illness or condition	\$60 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$60 (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$65	\$65	\$75
Other Practitioner Office Visit	\$60 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$60 (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$65	\$65	\$75
Specialist Visit	\$90 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$90 (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$100	\$100	\$100
Prenatal Care and Preconception Visit	\$0 (All Carriers)	50% Coinsurance after deductible	\$0	\$0 (All Carriers)	\$0 (All Carriers)	\$0	\$0	\$0
Urgent Care	\$60 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$60 (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$65	\$65	\$75
Laboratory Tests	\$55 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$55 (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$35	\$45	\$45 Copy after deductible
X-Rays and Diagnostic Imaging	\$90 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$90 (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$80	\$80 after deductible	45% Copy after deductible
Emergency Room Facility Fee (waived if admitted)	40% Coinsurance after deductible (All Carriers)	40% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Emergency Room Physician Fee (waived if admitted)	\$0 (All Carriers)	\$0	30% Coinsurance after deductible	\$0 (All Carriers)	Kaiser: 25% Coinsurance after deductible 50% Coinsurance after deductible (All other Carriers)	\$0	\$0	\$0
Emergency Medical Transportation	40% Coinsurance after deductible (All Carriers)	40% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Outpatient Surgery Facility Fee (e.g., ASC)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	ASC: \$100/ surgery + 30% Outpatient department to fee hospital: \$250/surgery + 30%	40% Coinsurance after deductible (All Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Outpatient Physician/ Surgeon Fee	40% (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	Kaiser 40% Coinsurance after deductible 40% (All Other Carriers)	25% Coinsurance after deductible (All Carriers)	45/50% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Outpatient 1 Visit	40% (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	40% (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$0	\$0	\$0
Inpatient Physician/Surgeon Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	Kaiser 40% Coinsurance after deductible 40% (All Other Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Inpatient Facility Fee (e.g., hospital room)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Durable Medical Equipment	40% (All Carriers)	50% Coinsurance after deductible	50% Coinsurance after deductible	40% (All Carriers)	25% Coinsurance after deductible (All Carriers)	46%	46%	46%
Imaging (CT/PET scans, MRIs)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	Outpatient Radiology center: 30% Outpatient department to hospital: \$100/visit + 30%	\$100 Copy after deductible (All Carriers)	25% Coinsurance after deductible (All Carriers)	\$400 Copy after deductible	\$400 Copy after deductible	\$400 Copy after deductible
Tier 1 (Generic Drugs)	BlueShield Level A \$25, Level B \$30	Not Covered	Level A: \$25 after deductible \$30 after deductible	BlueShield Access+/Trio: Level A \$20, Level B \$25 \$20 (All other Carriers)	25% Coinsurance after deductible (up to \$250 per Script) (All Carriers)	\$20	\$20	\$20
Tier 2 (Preferred Brand Drugs)	BlueShield Level A \$80 Copy after deductible, Level B \$105 Copy after deductible Sharp: \$80 Copy after deductible	Not Covered	Level A: 30% Coinsurance after deductible up to \$250 per script after deductible Level B: 40% Coinsurance up to \$250 per script after deductible	BlueShield Access+/Trio: Level A \$90 Copy after Pharmacy Deductible, Level B \$115 Copy after Pharmacy Deductible \$90 Copy after deductible (All other Carriers)	25% Coinsurance after deductible (up to \$250 per Script) (All Carriers)	\$100	\$100 Copy after Pharmacy Deductible	\$100 Copy after pharmacy deductible
Tier 3 (Non-preferred Brand Drugs)	BlueShield Level A \$110 copy after deductible, Level B \$150 copy after deductible Sharp: \$110 copy after deductible	Not Covered	Level A: 30% Coinsurance after deductible up to \$250 per script after deductible Level B: 40% Coinsurance up to \$250 per script after deductible	BlueShield Access+/Trio: Level A \$110 Copy after Pharmacy Deductible, Level B \$150 Copy after Pharmacy Deductible Kaiser: \$90 Copy after deductible \$110 (All other Carriers)	25% Coinsurance after deductible (up to \$250 per Script) (All Carriers)	\$100	\$100 Copy after Pharmacy Deductible	\$100 Copy after pharmacy deductible
Tier 4 (Specialty Drugs)	30% Coinsurance after deductible (All Carriers)	Not Covered	Level A: 30% Coinsurance after deductible up to \$250 per script after deductible Level B: 40% Coinsurance up to \$250 per script after deductible	30% Coinsurance (after pharmacy deductible up to \$250 per script) (All Carriers)	25% Coinsurance after deductible (up to \$250 per Script) (All Carriers)	30% Coinsurance after deductible (up to \$250 script)	30% Coinsurance after pharmacy deductible (up to \$250 script)	45% Coinsurance after deductible (up to \$250 script)
Mental/Behavioral Health Outpatient Office Visits	\$60 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$0 Kaiser \$60 (All other Carriers)	25% Coinsurance after deductible (All Carriers)	\$0	\$0	\$0
Mental/Behavioral Health Inpatient Physician Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	Kaiser 40% Coinsurance after deductible 40% (All Other Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Mental/Behavioral Health Inpatient Facility Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Substance Use Disorder Outpatient Office Visits	\$60 (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	\$0 Kaiser \$60 (All other Carriers)	25% Coinsurance after deductible (All Carriers)	\$0	\$0	\$0

Substance Use Disorder Inpatient Physician Fee	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	Kaiser 40% Coinsurance after deductible 40% (All Other Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Substance Use Inpatient Facility Fee (e.g., hospital room)	40% Coinsurance after deductible (All Carriers)	50% Coinsurance after deductible	30% Coinsurance after deductible	40% Coinsurance after deductible (All Carriers)	25% Coinsurance after deductible (All Carriers)	45% Coinsurance after deductible	45% Coinsurance after deductible	45% Coinsurance after deductible
Pediatric Dental	Pediatric Dental Embedded	Pediatric Dental Embedded	Pediatric Dental Embedded	Kaiser: Bundled Pediatric Dental Embedded (All other Carriers)	Kaiser: Bundled - Pediatric Dental Embedded (All other Carriers)	Bundled	Bundled	Bundled
MAXIMUM OUT-OF-POCKET FOR ONE	\$9,000 (All Carriers)	Blue Shield: \$18,000	\$8,700	\$9,200 (All Carriers)	\$8,700 (All Carriers)	\$9,500	\$9,800	\$9,800
MAXIMUM OUT-OF-POCKET FOR FAMILY	\$18,000 (All Carriers)	Blue Shield: \$36,000	\$17,400	\$18,400 (All Carriers)	\$17,600 (All Carriers)	\$19,000	\$19,600	\$19,600

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 Covered California for Small Notes

- 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.
- 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.
- 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.
- For plans except HDHPs, in coverage other than self-only coverage, an individual's payment towards 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 user pays all costs for covered services for all family members.
- 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 or 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.