



## Medical Plan Offerings - Blue Shield of California (BSCA) 2026\*

\*Carrier availability is based on client headquartered location, as well as client selection.

Information shown in this document does not include all plan details or changes. Refer to the Carrier Certificate on TriNet ([login.TriNet.com](http://login.TriNet.com)).

Disclaimer: © 2025 TriNet Group, Inc. All rights reserved. This communication is for informational purposes only, is not legal, tax or accounting advice, and is not an offer to buy, sell or procure insurance. In the event of any conflict with the official plan documents, the plan documents shall control. Communications and plan documents are subject to the terms, exclusions and limitations prescribed by the applicable insurance carrier certificates. TriNet is the single-employer sponsor of all its benefit plans, which does not include voluntary benefits that are not ERISA-covered group health insurance plans. TriNet reserves the right to amend the benefit plans or change the offerings and deadlines.

## Plan Offerings

Plan Highlights	BS-CA ACO 1700	BS-CA ACO 25	BS-CA ACO 40	BS-CA ACO/HDHP 4000 CA South	BS-CA ACO/PPO 300 CA South	BS-CA ACO/PPO 5000 CA South
Network Name	Blue Shield of California Tandem ACO/PPO Network	Blue Shield of California Trio ACO HMO network	Blue Shield of California Trio ACO HMO network	Blue Shield of California Tandem ACO/PPO Network	Blue Shield of California Tandem ACO/PPO Network	Blue Shield of California Tandem ACO/PPO Network
<b>Deductible</b>						
Single (In-Network/OON)	\$1,700 / \$3,400	\$0 / Not Covered	\$2,000 / Not Covered	\$4,000 / \$8,000	\$300 / \$600	\$5,000 / \$10,000
Family (In-Network/OON)	\$3,400 / \$6,800	\$0 / Not Covered	\$4,000 / Not Covered	\$8,000 / \$16,000	\$600 / \$1,200	\$10,000 / \$20,000
<b>Out-of-Pocket Max</b>						
Single (In-Network/OON)	\$6,000 / \$12,000	\$2,000 / Not Covered	\$5,000 / Not Covered	\$6,725 / \$14,000	\$3,000 / \$5,000	\$6,850 / \$13,700
Family (In-Network/OON)	\$12,000 / \$24,000	\$4,000 / Not Covered	\$10,000 / Not Covered	\$13,450 / \$28,000	\$5,000 / \$10,000	\$13,700 / \$20,000
Coinsurance (In-Network/OON)	25% / 50%	0% / Not Covered	40% / Not Covered	10% / 30%	15% / 35%	40% / 50%
Primary / Specialist	\$40 / \$60	\$25 / \$25	\$40 / \$40	10% after ded / 10% after ded	\$25 / \$50	\$45 / \$65
Lab & X-Ray	\$40 after ded	\$0	0%	10% after ded	\$25	\$45
Urgent Care Visit	\$40	\$25	\$40	10% after ded	\$25	\$45
Emergency Room Visit	25%	\$250	\$250	10% after ded	\$250 + 15%	40%
Hospital Outpatient (Facility / Surgery)	25% after ded / 25% after ded	\$250 / 0%	40% after ded / 0%	10% after ded / 10% after ded	15% after ded / 15% after ded	40% after ded / 40% after ded
Hospital Inpatient	25% after ded	\$350	40% after ded	10% after ded	\$250/admit + 15% after ded	40% after ded
Rx Deductible (Non-Generic)	N/A	N/A	\$100/\$300	Integrated w/Med	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	\$15 / \$50 / \$75	\$10 / \$35 / \$50	\$10 / \$40 after Rx ded / \$60 after Rx ded	\$10 after ded / \$35 after ded / \$55 after ded	\$10 / \$35 / \$50	\$15 / \$50 / \$75

## Plan Offerings

Plan Highlights	BS-CA HDHP 4000	BS-CA HDHP 5500	BS-CA HMO 20	BS-CA HMO 30	BS-CA PPO 1000	BS-CA PPO 1500
Network Name	Blue Shield of California PPO; nationally except Hawaii through Blue Card	Blue Shield of California PPO; nationally except Hawaii through Blue Card	Blue Shield of California Access+HMO	Blue Shield of California Access+HMO	Blue Shield of California PPO; nationally except Hawaii through Blue Card	Blue Shield of California PPO; nationally except Hawaii through Blue Card
<b>Deductible</b>						
Single (In-Network/OON)	\$4,000 / \$8,000	\$5,500 / \$11,000	\$0 / Not Covered	\$0 / Not Covered	\$1,000 / \$2,000	\$1,500 / \$3,000
Family (In-Network/OON)	\$8,000 / \$16,000	\$11,000 / \$22,000	\$0 / Not Covered	\$0 / Not Covered	\$2,000 / \$4,000	\$3,000 / \$6,000
<b>Out-of-Pocket Max</b>						
Single (In-Network/OON)	\$6,725 / \$14,000	\$6,550 / \$15,000	\$2,000 / Not Covered	\$2,000 / Not Covered	\$4,000 / \$8,000	\$5,500 / \$11,000
Family (In-Network/OON)	\$13,450 / \$28,000	\$13,100 / \$30,000	\$4,000 / Not Covered	\$4,000 / Not Covered	\$8,000 / \$16,000	\$11,000 / \$22,000
Coinsurance (In-Network/OON)	10% / 30%	40% / 50%	0% / Not Covered	0% / Not Covered	20% / 40%	25% / 50%
Primary / Specialist	10% after ded / 10% after ded	40% after ded / 40% after ded	\$20 / \$20	\$30 / \$30	\$30 / \$60	\$35 / \$70
Lab & X-Ray	10% after ded	40% after ded	0%	0%	\$30	\$35
Urgent Care Visit	10% after ded	40% after ded	\$20	\$30	\$30	\$35
Emergency Room Visit	10% after ded	40% after ded	\$250	\$250	20%	25%
Hospital Outpatient (Facility / Surgery)	10% after ded / 10% after ded	40% after ded / 40% after ded	\$150 / 0%	\$300 / 0%	20% after ded / 20% after ded	25% after ded / 25% after ded
Hospital Inpatient	10% after ded	40% after ded	\$350	\$500	20% after ded	25% after ded
Rx Deductible (Non-Generic)	Integrated w/Med	Integrated w/Med	N/A	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	\$10 after ded / \$35 after ded / \$55 after ded	\$15 after ded / \$50 after ded / \$75 after ded	\$10 / \$35 / \$50	\$10 / \$35 / \$50	\$10 / \$35 / \$50	\$10 / \$35 / \$50

## Plan Offerings

Plan Highlights	BS-CA PPO 300	BS-CA PPO 500	BS-CA PPO 5000	BS-CA PPO 700
Network Name	Blue Shield of California PPO; nationally except Hawaii through Blue Card	Blue Shield of California PPO; nationally except Hawaii through Blue Card	Blue Shield of California PPO; nationally except Hawaii through Blue Card	Blue Shield of California PPO; nationally except Hawaii through Blue Card
<b>Deductible</b>				
Single (In-Network/OON)	\$300 / \$600	\$500 / \$1,000	\$5,000 / \$10,000	\$700 / \$1,400
Family (In-Network/OON)	\$600 / \$1,200	\$1,500 / \$2,000	\$10,000 / \$10,000	\$1,800 / \$2,800
<b>Out-of-Pocket Max</b>				
Single (In-Network/OON)	\$3,000 / \$5,000	\$4,000 / \$7,000	\$6,850 / \$13,700	\$4,000 / \$8,000
Family (In-Network/OON)	\$5,000 / \$10,000	\$8,000 / \$14,000	\$13,700 / \$20,000	\$8,000 / \$16,000
Coinsurance (In-Network/OON)	15% / 35%	15% / 35%	40% / 50%	20% / 40%
Primary / Specialist	\$25 / \$50	\$30 / \$60	\$45 / \$65	\$30 / \$60
Lab & X-Ray	\$25	\$30	\$45	\$30
Urgent Care Visit	\$25	\$30	\$45	\$30
Emergency Room Visit	\$250 + 15%	\$250 + 15%	40%	20%
Hospital Outpatient (Facility / Surgery)	15% after ded / 15% after ded	15% after ded / 15% after ded	40% after ded / 40% after ded	20% after ded / 20% after ded
Hospital Inpatient	\$250/admit + 15% after ded	\$250/admit + 15% after ded	40% after ded	20% after ded
Rx Deductible (Non-Generic)	N/A	N/A	N/A	N/A
Prescriptions (Tier 1 / 2 / 3)	\$10 / \$35 / \$50	\$10 / \$30 / \$50	\$15 / \$50 / \$75	\$10 / \$35 / \$50