2027 Individual & Family Patient Centered Benefit Designs

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		Silver 87		Silver 94		Bronze		Bronze HDHP		Catastrophic	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,800		$15,600
Medical Deductible										$4,700		$4,700		$1,100		$200		$5,800				
Drug Deductible										$50		$50		$50		$0		$450				
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%		10%		40%		0%		0%
MOOP		$5,500		$5,500		$9,600		$9,600		$11,650		$9,600		$4,000		$3,000		$11,650		$7,800		$15,600
ED Facility Fee		$225		$225		$350		$350		$400		$400		$200		$50	X	40%	X	0%	X	0%
Inpatient Facility Fee		10%		$325		30%		$375	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		20%		10%	X	40%	X	0%	X	0%
Primary Care Visit		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Specialist Visit		$45		$45		$80		$80		$100		$100		$30		$8	X	$100	X	0%	X	0%
MH/SU Outpatient Services		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Imaging (CT/PET Scans, MRIs)		15%		$90		25%		$125		$325		$325		$100		$50	X	40%	X	0%	X	0%
Speech Therapy		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Occupational and Physical Therapy		$20		$20		$40		$40		$50		$50		$15		$5		$60	X	0%	X	0%
Laboratory Services		$25		$25		$40		$40		$50		$50		$35		$10		$50	X	0%	X	0%
X-rays and Diagnostic Imaging		$35		$35		$85		$85		$95		$95		$50		$10	X	40%	X	0%	X	0%
Skilled Nursing Facility		10%		$175		30%		$150	X	30%	X	30%	X	20%	X	10%	X	40%	X	0%	X	0%
Outpatient Facility Fee		10%		$100		30%		$150		30%		30%		20%		10%	X	40%	X	0%	X	0%
Outpatient Physician Fee		10%		$50		30%		$75		30%		30%		20%		10%	X	40%	X	0%	X	0%
Tier 1 (Generics)		$10		$10		$19		$19		$20		$20		$10		$3		$20	X	0%	X	0%
Tier 2 (Preferred Brand)		$25		$25		$60		$60	X	$65	X	$55	X	$30		$10	X	40%	X	0%	X	0%
Tier 3 (Nonpreferred Brand)		$45		$45		$90		$90	X	$95	X	$95	X	$50		$15	X	40%	X	0%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	40%	X	0%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*				
Maximum Days for charging IP copay				5				5														
Begin Specialist deductible after # of copays																		3				
Actuarial Value																						
2027 AV Calculator		**91.76**		**91.55**		**81.22**		**81.92**		**71.61†**		**73.78†**		**87.87†**		**94.89**		**63.02†**		**64.91**		**Not supported in AV Calculator**

KEY				
	X	Subject to deductible		Decreased member cost from 2026
	*	Drug cap applies to all drug tiers		Does not meet AV
	†	Additive adjustment (included in AV)		Within .5 of upper de minimis
		Increased member cost from 2026		Securely within AV

2027 Covered California for Small Business Benefit Designs

Benefit	CCSB-only Platinum Coinsurance		CCSB-only Platinum Copay		CCSB-only Gold Coinsurance		CCSB-only Gold Copay		CCSB-only Silver Coinsurance		CCSB-only Silver Copay		CCSB-only Silver HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														$3,200
Medical Deductible						$500		$325		$2,500		$2,500		
Drug Deductible						$0		$0		$350		$350		
Coinsurance (Member)		10%		10%		20%		20%		40%		40%		25%
MOOP		$5,000		$5,000		$8,600		$8,600		$9,000		$9,200		$8,800
ED Facility Fee		$250		$250	X	20%	X	$300	X	40%	X	40%	X	25%
Inpatient Facility Fee		10%		$300	X	20%	X	$600	X	40%	X	40%	X	25%
Inpatient Physician Fee		10%		---	X	20%		--	X	40%		40%	X	25%
Primary Care Visit		$25		$25		$30		$40		$60		$60	X	25%
Specialist Visit		$40		$40		$60		$60		$90		$90	X	25%
MH/SU Outpatient Services		$25		$25		$30		$40		$60		$60	X	25%
Imaging (CT/PET Scans, MRIs)		15%		$150		20%	X	$350	X	40%	X	$300	X	25%
Speech Therapy		$25		$25		$30		$40		$60		$60	X	25%
Occupational and Physical Therapy		$25		$25		$30		$40		$60		$60	X	25%
Laboratory Services		$25		$20		$25		$40		$55		$55	X	25%
X-rays and Diagnostic Imaging		$45		$35		$65		$60		$90		$90	X	25%
Skilled Nursing Facility		10%		$150	X	20%	X	$500	X	40%	X	40%	X	25%
Outpatient Facility Fee		10%		$100		20%	X	$300	X	40%	X	40%	X	25%
Outpatient Physician Fee		10%		$35		20%		$50		40%		40%	X	25%
Tier 1 (Generics)		$10		$10		$20		$15		$25		$20	X	25%
Tier 2 (Preferred Brand)		$30		$25		$50		$50	X	$80	X	$90	X	25%
Tier 3 (Nonpreferred Brand)		$40		$40		$80		$70	X	$110	X	$110	X	25%
Tier 4 (Specialty)		10%		10%		20%		20%	X	30%	X	30%	X	25%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$250*
Maximum Days for charging IP copay				5				5						
Begin PCP deductible after # of copays														
Actuarial Value														
2027 AV Calculator		**91.76**		**91.89**		**80.32**		**81.17**		**71.14†**		**71.45†**		**71.46**

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2026
		Decreased member cost from 2026
		Does not meet AV
		Within .5 of de minimis
		Securely within AV