2027 PATIENT-CENTERED BENEFIT PLAN DESIGNS

Individual & Family Plans

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		$12,000
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		$12,000
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**

2027 PATIENT-CENTERED BENEFIT PLAN DESIGNS

Covered California for Small Business

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		$8,700
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**		**71.54**