



2027 Dental Benefit Plan Designs

Date: March 19, 2026

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.

Individual and Small Business				
Children's Dental Plan				
Coinsurance Plan			Copoly Plan	
Pediatric Dental EHB			Pediatric Dental EHB	
Up to Age 19			Up to Age 19	
Actuarial Value	87.6%	87.6%	89.9%	
	In-Network	Out-of-Network	In-Network	
Individual Deductible	\$75	\$75	None	
Family Deductible (Two or more children)	\$150	\$150	Not Applicable	
Individual Out of Pocket Maximum	\$350	None	\$350	
Family Out of Pocket Maximum (Two or More Children)	\$700	None	\$700	
Office Copay	\$0	\$0	\$0	
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))	None	None	None	
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)	None	None	None	
Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge	10%	No charge
	Preventive - Cleaning	No charge	10%	No charge
	Preventive - X-ray	No charge	10%	No charge
	Sealants per Tooth	No charge	10%	No charge
	Topical Fluoride Application	No charge	10%	No charge
	Space Maintainers - Fixed	No charge	10%	No charge
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	See 2027 Dental Copay Schedule
	Periodontal Maintenance Services			
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	See 2027 Dental Copay Schedule
	Endodontics			
	Crowns and Casts			
	Prosthodontics			
	Oral Surgery			
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	\$350



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Individual and Small Business					
Family Dental Plan					
Coinsurance Plan					
Pediatric Dental EHB			Adult Dental		
Up to Age 19			Age 19 and Older		
Actuarial Value		87.6%	87.6%	Not Calculated	Not Calculated
		In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible		\$75	\$75	\$50	\$50
Family Deductible (Two or more children)		\$150	\$150	Not Applicable	Not Applicable
Individual Out of Pocket Maximum		\$350	None	Not Applicable	Not Applicable
Family Out of Pocket Maximum (Two or More Children)		\$700	None	Not Applicable	Not Applicable
Office Copay		\$0	\$0	\$0	\$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))		None	None	6 months for Major Services, Waived with Proof of Prior Coverage	6 months for Major Services, Waived with Proof of Prior Coverage
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None	None	\$1,500	
Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge	10%	No Charge	10%
	Preventive - Cleaning	No charge	10%	No Charge	10%
	Preventive - X-ray	No charge	10%	No Charge	10%
	Sealants per Tooth	No charge	10%	No Charge if Covered	10% if Covered
	Topical Fluoride Application	No charge	10%	No Charge if Covered	10% if Covered
	Space Maintainers - Fixed	No charge	10%	No Charge if Covered	10% if Covered
Basic Services	Restorative Procedures	20%	30%	20%	30%
	Periodontal Maintenance Services	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies
	Endodontics				
	Crowns and Casts				
	Prosthodontics				
	Oral Surgery				
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered



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Individual and Small Business			
Family Dental Plan			
Copay Plan			
		Pediatric Dental EHB	Adult Dental
		Up to Age 19	Age 19 and Older
Actuarial Value		89.9%	Not Calculated
		In-Network	In-Network
Individual Deductible		None	None
Family Deductible (Two or more children)		Not applicable	Not Applicable
Individual Out of Pocket Maximum		\$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)		\$700	Not Applicable
Office Copay		\$0	\$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))		None	None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None	None
Procedure Category	Service Type	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	No charge	No Charge
	Preventive - Cleaning	No charge	No Charge
	Preventive - X-ray	No charge	No Charge
	Sealants per Tooth	No charge	No Charge if Covered
	Topical Fluoride Application	No charge	No Charge if Covered
	Space Maintainers - Fixed	No charge	No Charge if Covered
Basic Services	Restorative Procedures	See 2027 Dental Copay Schedule	See 2027 Dental Copay Schedule
	Periodontal Maintenance Services		
Major Services	Periodontics (other than maintenance)	See 2027 Dental Copay Schedule	See 2027 Dental Copay Schedule
	Endodontics		
	Crowns and Casts		
	Prosthodontics		
	Oral Surgery		
Orthodontia	Medically Necessary Orthodontia	\$350	Not Covered