Standard Benefit Design - Overview

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The Importance of Standard Benefit Designs

- **Standard benefit designs** are health insurance cost-sharing configurations that specify enrollee out of pocket amounts, e.g. deductibles, copays and coinsurance for covered services and prescription drugs.

- The Covered California Board of Directors is authorized under state law to standardize products offered through the Exchange and **contracted plans are required to offer products using Covered California's Board-approved standard benefit design plans.**

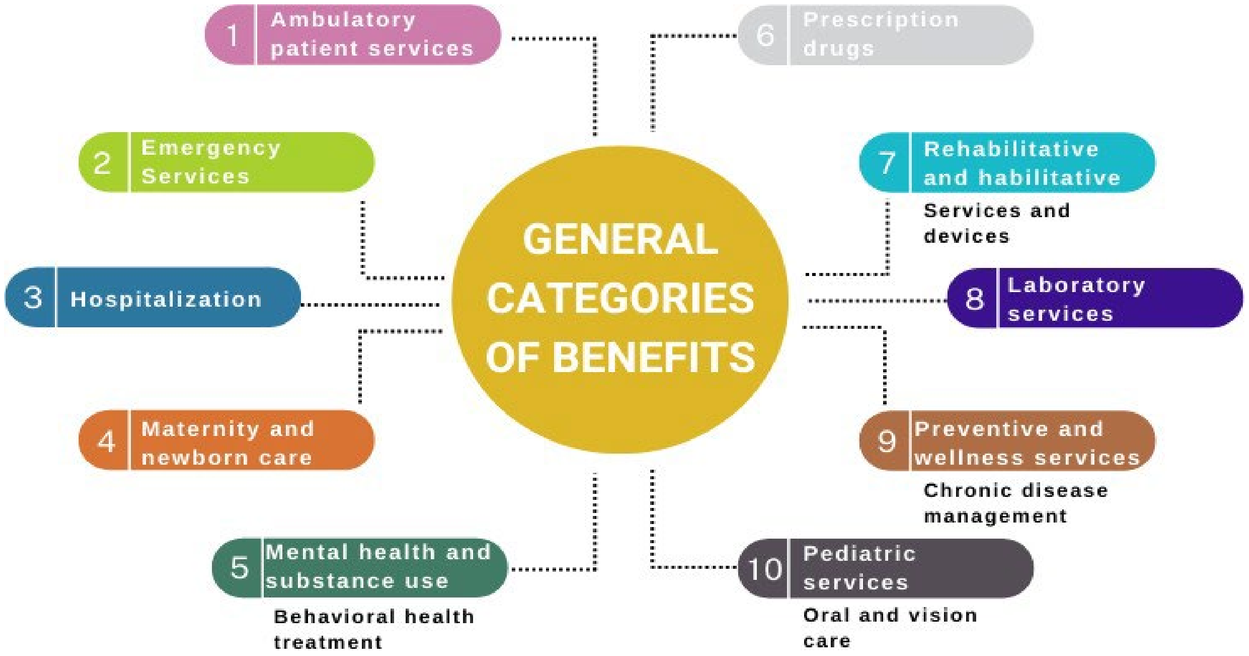
- Standardizing plan designs allows consumers to make apples to apples comparisons between plans available through Covered California, **allowing consumers to focus their choice on plan premium, network, and quality.**

- The standard **benefit plan designs are adjusted annually** to meet federal actuarial value (AV) requirements, clarify benefit administration, and incorporate benefit design innovations.

- **Covered California convenes a standard benefit workgroup** that is open to the public to help shape the standard benefit design every year and in accordance with federal requirements. The workgroup proposes the standard benefit design every Spring to the Covered CA Board of Directors for approval and implementation for the following plan year.

Overview of Essential Health Benefits

The Patient Protection and Affordable Care Act (PPACA, or ACA) requires that all health insurance plans offered in the individual and small-group markets must provide a comprehensive package of items and services, known as essential health benefits (EHBs). These benefits fit into the following 10 categories:



Covered California's covered benefits are based on those identified in our benchmark plan, which was adopted by legislation in 2012. Plans offered on the Exchange must include all the benefits in this plan, and cannot include benefits not included in this plan unless required by Federal legislation, or is otherwise defrayed (i.e. cannot be paid for by premiums). Details of the plan can be found here: https://www.cms.gov/cciio/resources/data-resources/downloads/updated-california-benchmark-summary.pdf. California submitted a proposed revision to our benchmark plan in May 2025 but review by CMS has been suspended.

Standard Benefit Designs – Federal Influence

- In the fall of each year, Centers for Medicaid and Medicare Services (CMS) releases a draft AV Calculator (AVC) and Notice of Benefit and Payment Parameters (NBPP). The AVC and NBPP are used to model how benefit cost shares can be changed to ensure all plans fit within the *de minimis* range for each metal tier.
    - This year, the draft NBPP and AV Calculator were released very late in the cycle, at the beginning of March, delaying our work to update the benefit designs for PY2027 and compressing the design update timeline
- CMS also updates the Maximum Out of Pocket (MOOP) and cost sharing limitations for cost-sharing reduction silver plans
- New rules have been proposed that would expand eligibility for Catastrophic (AKA Minimum Coverage) plans
    - These do cover preventive services but are automatically set at the highest MOOP, and this year there is a proposal to set this at 130% of the normal MOOP

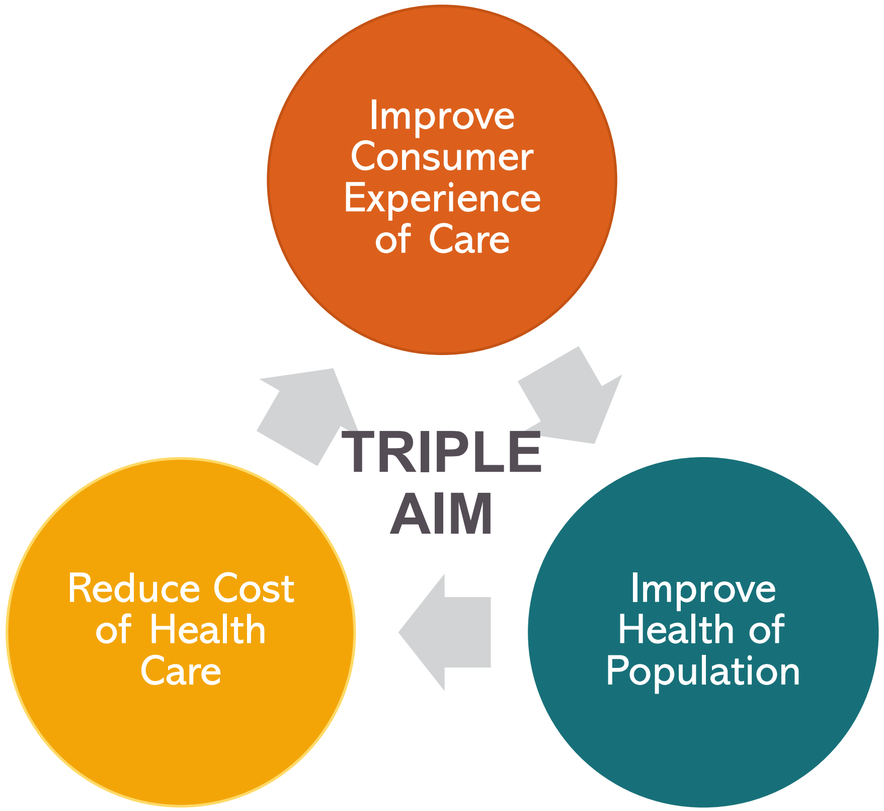
Strategy for Patient-Centered Benefit Plan Designs

Organizational Goal

Covered California should have benefit designs that are standardized, promote access to care, and are easy for consumers to understand, i.e., **PATIENT-CENTERED**

Principles

- Multi-year progressive strategy with consideration for market dynamics: changes in benefits should be considered annually based on consumer experience related to access and cost
- Adhere to principles of value-based insurance design by considering value and cost of clinical services
- Set fixed copays as much as possible and utilize coinsurance for services with wide price variation to encourage members to shop for services
- Apply a stair-step approach for setting member cost shares for a service across each metal level, e.g., for Plan Year 2026, a Primary Care visit was $50 in the Silver tier, $40 in Gold, and $15 in Platinum

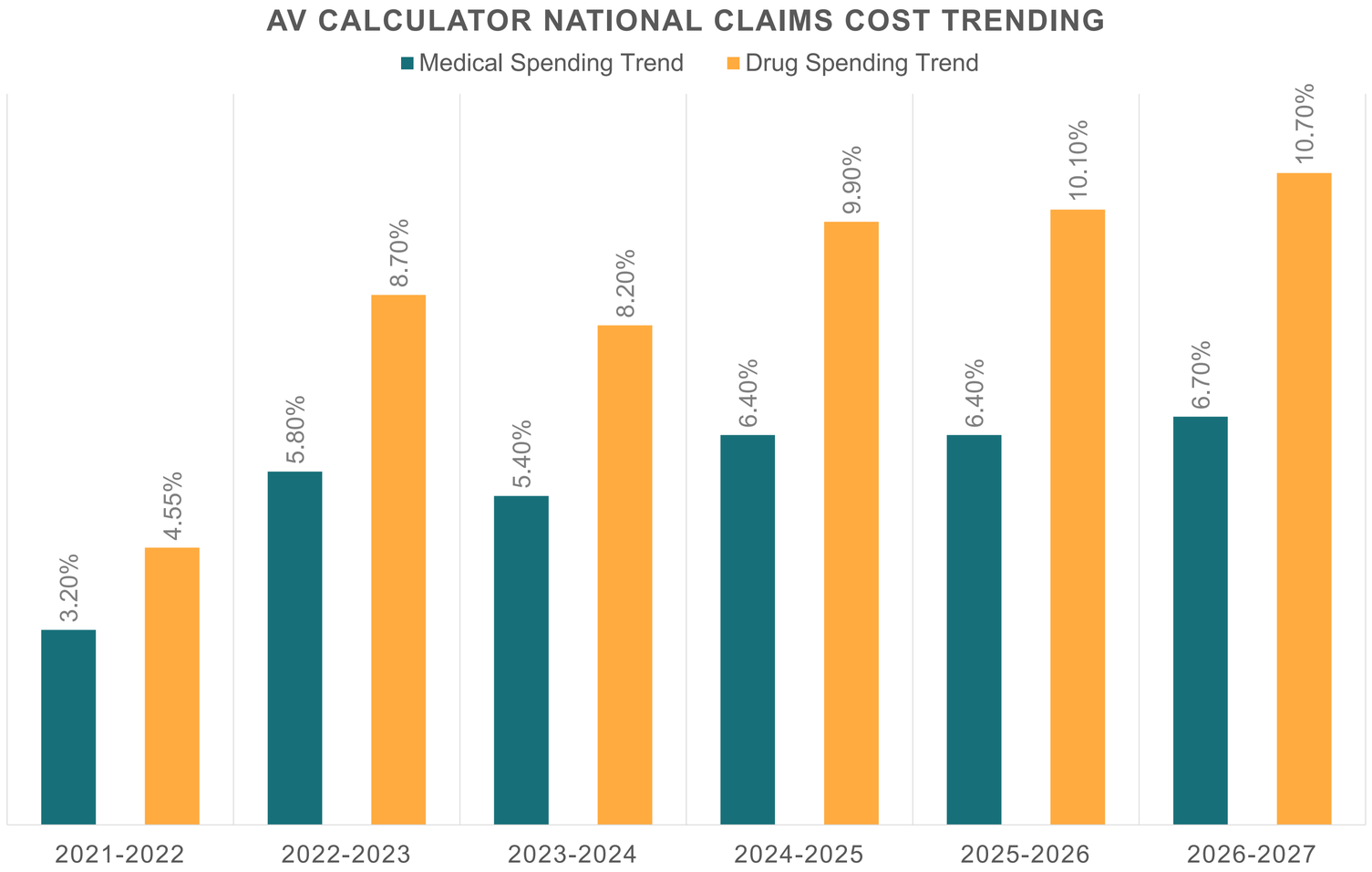


Benefit Design Requirements

- The ACA requires individual and small group plans to meet actuarial value (AV) requirements for four levels of coverage:
  - Platinum: 90% AV
  - Gold: 80% AV
  - Silver: 70% AV
  - Bronze: 60% AV

- Additional plan designs with a richer benefit package, known as “Cost Sharing Reduction Plans”, are available to individuals meeting income eligibility requirements
  - Silver 94: 94% AV, 100% - 150% Federal Poverty Level (FPL)
  - Silver 87: 87% AV, 150% - 200% FPL
  - Silver 73: 73% AV, 200% - 250% FPL

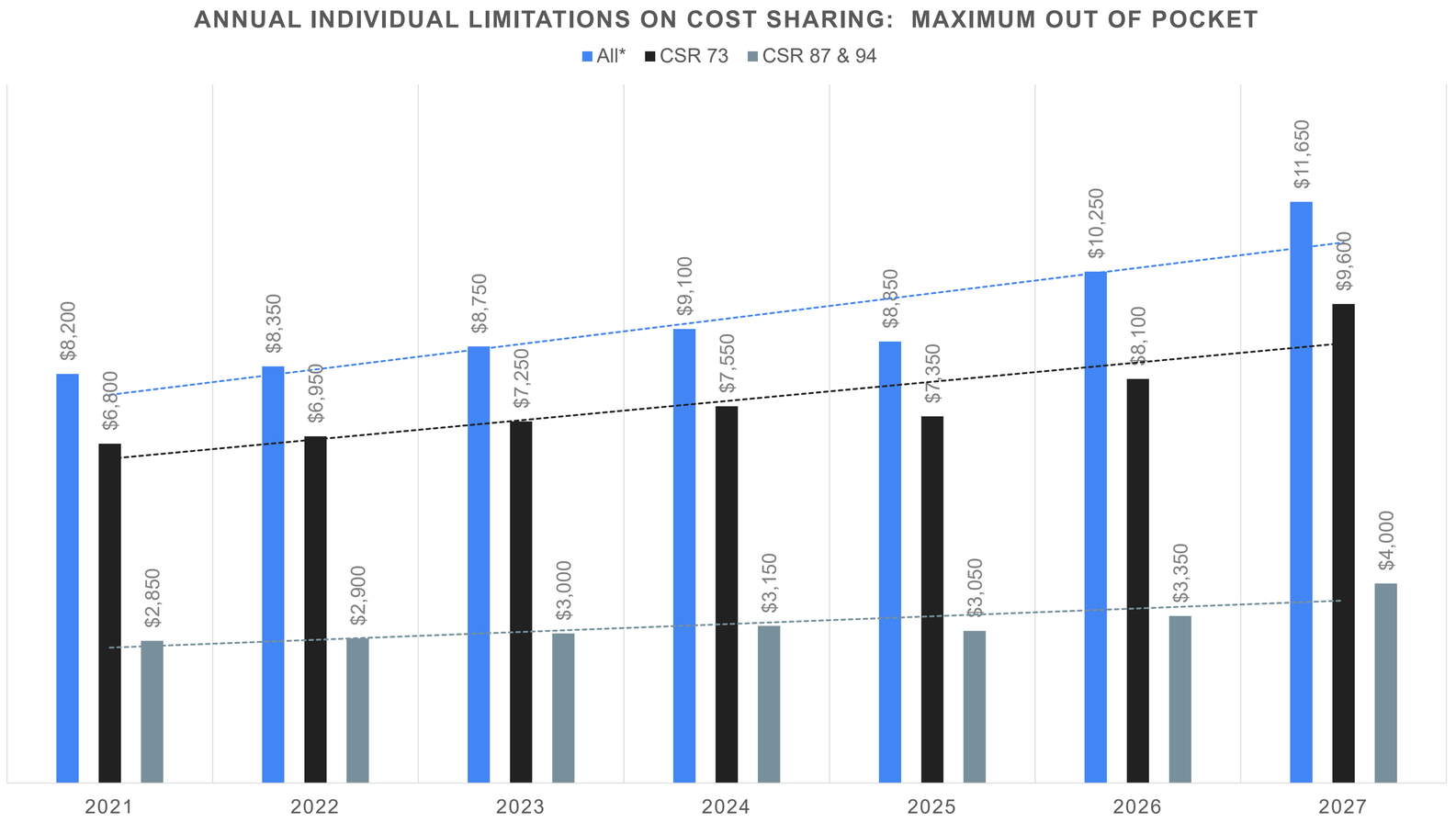
AV Calculator Update and Trends



- Claims cost trending continues to rise in the PY2027 AV Calculator at a rate more rapid rate than in previous years, with drugs increasing at a faster pace

- These trends underlie the function of the AV calculator and are part of what drives the needed increases in cost sharing to bring the plans back into AV compliance

2027 Annual Limitation on Cost Sharing



- Annual limitation on cost sharing continues to rise faster than inflation, and 2026 and 2027 represent a change in the methodology such that a higher premium trend factor yields a higher maximum out of pocket (MOOP)
- High MOOPs have been shown to be a primary driver of medical debt but increasing the MOOP on our plans was required to achieve AV targets

Notes: Non-CSR MOOP is Less Covered California $350 Dental MOOP

Family MOOP is double the individual MOOP

AV Changes From 2026 to 2027 & De Minimis Ranges – Baseline Modeling

	Bronze		Silver				Gold		Platinum	
	HDHP	Standard	Silver	Silver 73	Silver 87	Silver 94	Copay	Coins	Copay	Coins
AV Target	60	60	70	73	87	94	80	80	90	90
Deviation Allowance	+5/-4%	+5/-4%	+2/0%	+1/0%	+1/0%	+1/0%	+2/-2%	+2/-2%	+2/-2%	+2/-2%
2026 Final AV	64.76	63.49	71.66	73.69	87.80	94.81	81.64	81.46	91.58	91.90
2026 CA Enhanced CSR AV			**81.56**	**81.56**	**90.83**	**97.04**				
2027 AV	**66.16**	**65.08**	**73.92**	**75.94**	**89.42**	**96.63**	**83.05**	**81.93**	**93.84**	**93.43**

CCSB ONLY	Silver			Gold		Platinum	
	Copay	Coins	HDHP	Copay	Coins	Copay	Coins
AV Target	70	70	70	80	80	90	90
Deviation Allowance	+2/-2%	+2/-2%	+/-2%	+2/-2%	+/-2%	+2/-2%	+2/-2%
2026 Final AV	70.81	71.17	70.61	81.70	80.25	91.13	91.79
2027 AV	**72.10**	**72.49**	**71.84**	**83.02**	**81.98**	**93.38**	**93.42**

*Draft AV does not include 2027 copay accumulation additive adjustment or custom inputs- these are pending and subject to change

Red text: AV is outside de minimis range

Green text: AV is within de minimis range

Yellow text: AV is within de minimis range but could be too high to accommodate final AV adjustments and buffer for MHPAEA outcomes

Blue text: 2027 CA Enhanced CSR AV

PY2027 Individual Design Models

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PY2027 Proposed Patient Centered Benefit Designs

Benefit	Individual-only Platinum Coinsurance H		Individual-only Platinum Copay H		Individual-only Gold Coinsurance D		Individual-only Gold Copay D		Individual-only Silver J		Silver 73 D		CA Enhanced CSR Silver 73		Silver 87 E		CA Enhanced CSR Silver 87		Silver 94 C		CA Enhanced CSR Silver 94		Bronze F		Bronze HDHP A	
	Ded	Amount	Ded	Amount	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
Medical Deductible										$4,700		$4,700		$0		$1,100		$0		$200		$0		$5,800		
Drug Deductible										$50		$50		$0		$50		$0		$0		$0		$450		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		30%		20%		20%		10%		10%		40%		0%
MOOP		$5,500		$5,500		$9,600		$9,600		$11,650		$9,600		$6,100		$4,000		$3,000		$3,000		$1,150		$11,650		$7,800
ED Facility Fee		$225		$225		$350		$350		$400		$400		$350		$200		$150		$50		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$325		30%		$375	X	30%	X	30%		30%	X	20%		20%	X	10%		10%	X	40%	X	0%
Inpatient Physician Fee		---		---		30%		---		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%
Primary Care Visit		$20		$20		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Specialist Visit		$45		$45		$80		$80		$100		$100		$85		$30		$25		$8		$8	X	$100	X	0%
MH/SU Outpatient Services		$20		$20		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Imaging (CT/PET Scans, MRIs)		15%		$90		25%		$125		$325		$325		$325		$100		$100		$50		$50	X	40%	X	0%
Speech Therapy		$20		$20		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Occupational and Physical Therapy		$20		$20		$40		$40		$50		$50		$35		$15		$15		$5		$5		$60	X	0%
Laboratory Services		$25		$25		$40		$40		$50		$50		$50		$35		$20		$10		$8		$50	X	0%
X-rays and Diagnostic Imaging		$35		$35		$85		$85		$95		$95		$95		$50		$40		$10		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$175		30%		$150	X	30%	X	30%		30%	X	20%		20%	X	10%		10%	X	40%	X	0%
Outpatient Facility Fee		10%		$100		30%		$150		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$50		30%		$75		30%		30%		30%		20%		20%		10%		10%	X	40%	X	0%
Tier 1 (Generics)		$10		$10		$19		$19		$20		$20		$15		$10		$5		$3		$3		$20	X	0%
Tier 2 (Preferred Brand)		$25		$25		$60		$60	X	$65	X	$55		$55	X	$30		$25		$10		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$45		$45		$90		$90	X	$95	X	$95		$85	X	$50		$45		$15		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%		20%	X	15%		15%		10%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$250		$150		$150		$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**		**73.79**		**81.56**		**87.81**		**90.83**		**94.90**		**97.04**		**62.93**		**64.91**
September 2025 Enrollment		62,120				109,310				48,760		606,850				469,800				228,780				350,960		81,340
Percent of Total enrollment		3.2%				5.5%				2.5%		30.8%				23.8%				11.6%				17.8%		4.1%
Percent of Total enrollment		29%		71%		53%		47%																		

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
		Enhanced member cost from 2027
		Does not meet AV
		Within .5 of upper de minimis
		Securely within AV

PY2027 Covered California for Small Business Design Models

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Covered California for Small Business Approach

- Covered California also offers plans in the Small Group Market
- These plans are subject to the same maximum out of pocket (MOOP) limits, though have a lower deductible
- Premiums are paid by employers, who tend to be price sensitive, and are not eligible for the subsidies offered in the individual market
- We design these plans to be competitive in a marketplace where the competition offers carrier-designed plans but continue to focus on enrollee experience and value-based design

CCSB Proposed Benefit Designs

Benefit	CCSB-only Platinum Coinsurance I		CCSB-only Platinum Copay F		CCSB-only Gold Coinsurance F		CCSB-only Gold Copay J		CCSB-only Silver Coinsurance C		CCSB-only Silver Copay F		CCSB-only Silver HDHP A	
	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	X	$50	X	$50	X	$80	X	$90	X	25%
Tier 3 (Nonpreferred Brand)		$40		$40	X	$80	X	$70	X	$110	X	$110	X	25%
Tier 4 (Specialty)		10%		10%	X	20%	X	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**		**80.40**		**81.17**		**70.85**		**71.12**		**71.43**

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		Does not meet AV
		Within .5 of de minimis
		Securely within AV

Dental Benefit Background

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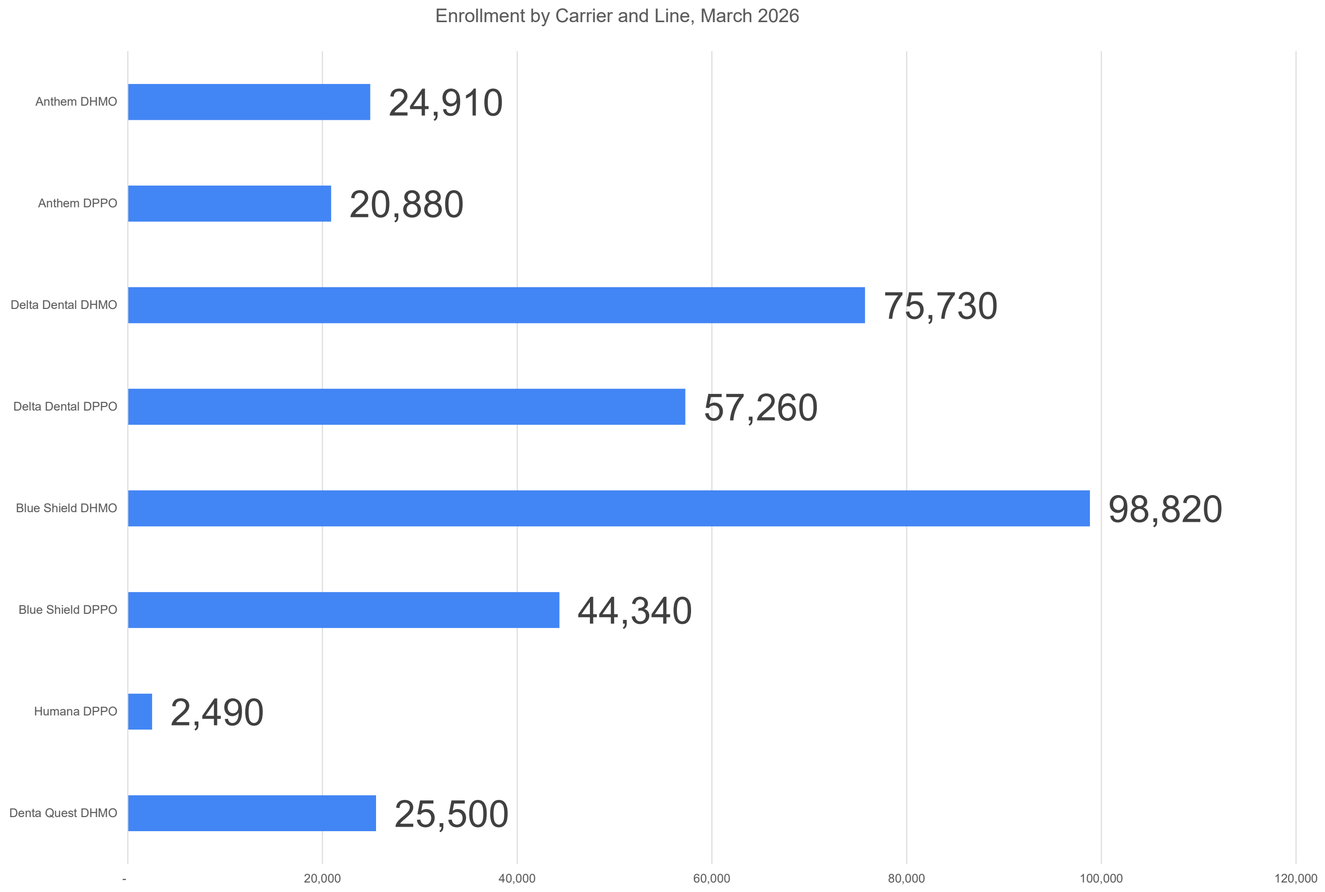
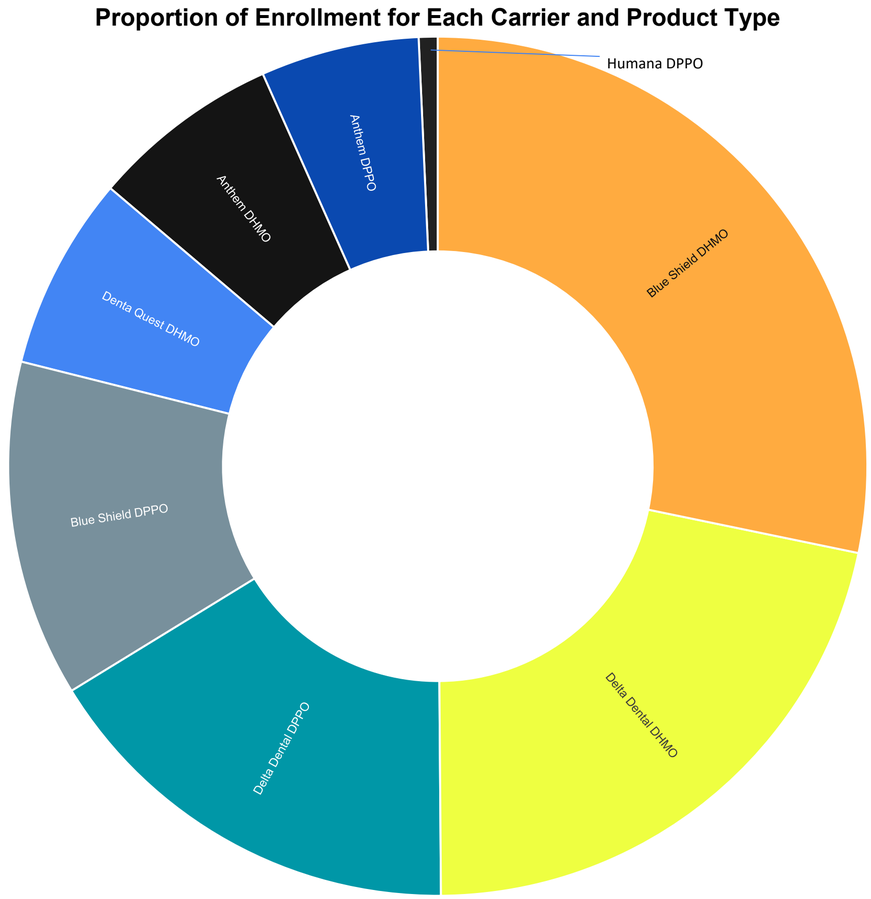
Qualified Dental Plans

- First offered in plan year 2016
- Covered California requires at least one adult to enroll in a qualified health plan (QHP) before they and their family may purchase a stand-alone qualified dental plan (QDP)
- QDPs offer Family Dental Plans that combine children's and adult dental benefits
  - Adults can enroll without enrolling children into Family Dental Plans
  - If a family enrolls one child, they must enroll all children and at least one adult
- QDPs must include pediatric essential health benefits (EHB) to be certified and available on the Exchange
- Advanced Premium Tax Credits (APTC) cannot be applied to dental premium

Standalone Dental Enrollment





Source: CalHEERS enrollment as of 3/1/2026

Total Enrollment: 349,930

Pediatric Embedded Dental Essential Health Benefit

QHP Issuer	Embedded Dental Carrier
Aetna	Liberty Dental Plan DHMO
Anthem Blue Cross HMO	Anthem Blue Cross DHMO
Anthem Blue Cross EPO	Anthem Blue Cross DPPO
Blue Shield HMO	Dental Benefit Providers DHMO
Blue Shield PPO	Dental Benefit Providers DPPO
Chinese Community	Delta Dental of California DHMO
Health Net HMO	Dental Benefit Providers DHMO
Health Net PPO	Dental Benefit Providers DPPO
IEHP	Liberty Dental Plan DHMO
Kaiser	Delta Dental of California DHMO
LA Care	Liberty Dental Plan DHMO
Molina Health Care	California Dental Network DHMO
SHARP	Delta Dental DHMO
Valley Health	Liberty Dental Plan DHMO
Western Health	Delta Dental of California DHMO

- Enrollees younger than 19 enrolled in a QHP are also enrolled in an embedded Pediatric Dental Plan
- Scope of benefits is determined by Denti-Cal's 2014 children's dental plan
- Beginning in plan year 2015, CMS set the standalone dental plan Maximum out-of-pocket (MOOP) at $350 per child and $700 for two or more enrolled children
- In 2018, CMS removed the Actuarial Value requirement for children's dental plans, however Covered CA still calculates AV to guide benefit design

Dental CDT Code Updates

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Update to CDT Codeset – Revisions, Editorial Changes and Deletions

Revision Codes	New Nomenclature
D0180	comprehensive periodontal evaluation – new or established patient
D2391	resin-based composite – one surface, posterior
D5876	add metal substructure to acrylic complete denture – per arch
D5934	mandibular guidance prosthesis with guide flange
D5935	mandibular guidance prosthesis without guide flange
D7285	incisional biopsy of oral tissue – hard (bone, tooth)
D7286	incisional biopsy of oral tissue – soft
D9222	administration of deep sedation/general anesthesia – first 15 minute increment, or any portion thereof
D9223	administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof
D9230	administration of nitrous oxide
D9239	administration of moderate sedation – intravenous – first 15 minute increment, or any portion thereof
D9243	administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof

Editorial Codes	New Nomenclature
D4263	bone replacement graft – retained natural tooth – first site in quadrant
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant
D5863	overdenture – complete maxillary – natural tooth borne
D5864	overdenture – partial maxillary – natural tooth borne
D5865	overdenture – complete mandibular – natural tooth borne
D5866	overdenture – partial mandibular – natural tooth borne
D5982	surgical stent for soft tissue healing
D6080	implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments

Deleted Codes	Nomenclature
D1352	preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D9248	non-intravenous conscious sedation

Update to CDT Codeset - Additions

New Code	Nomenclature	Proposed Pediatric Copay	Proposed Adult Copay
D5909	maxillary guidance prosthesis with guide flange	$350	Not Covered
D5930	maxillary guidance prosthesis without guide flange	$350	Not Covered
D5938	resection prosthesis, maxillary complete removable	$350	$350
D5939	resection prosthesis, mandibular complete removable	$350	$350
D5940	resection prosthesis, maxillary partial removable	$350	$350
D5941	resection prosthesis, mandibular partial removable	$350	$350
D5942	resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	$350	Not Covered
D5943	resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	$350	Not Covered
D5944	resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	$350	Not Covered
D5945	resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	$350	Not Covered
D5946	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	$350	Not Covered
D5947	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	$350	Not Covered
D5948	resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	Not Covered
D5949	resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	Not Covered
D6049	scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	$35	Not Covered
D6280	implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments – per arch	$20	Not Covered
D9224	administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof	$65	$65
D9225	administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof	$65	$65
D9244	in-office administration of minimal sedation – single drug – enteral	$30	Not Covered
D9245	administration of moderate sedation – enteral	$65	$65
D9246	administration of moderate sedation – non-intravenous parenteral – first 15 minute increment, or any portion thereof	$65	$65
D9247	administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof	$65	$65

Questions

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