State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 6458
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 11346.1 and 11349.6

OAL File No. 2014-0307-01 EE

The California Patient Protection and Affordable Care Act established the California Health Benefit Exchange (HBEX). HBEX is responsible for arranging and contracting with health insurance issuers to provide affordable, quality health insurance coverage to qualified individuals and qualified employers through the Exchange. In this emergency readopt, HBEX adopts the 2014 Standard Benefit Plan Designs, which standardizes the way health plans are designed.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 3/17/2014 and will expire on 6/17/2014. The Certificate of Compliance for this action is due no later than 6/16/2014.

Date: 3/17/2014

Thanh Huynh
Attorney

For: DEBRA M. CORNEZ
Director

Original: Peter Lee
Copy: Brandon Ross

STATE OF CALIFORNIA–OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

EMERGENCY

(See instructions on reverse)

STD. 400 (REV. 01-2013)

For use by Secretary of State only

ENDORSED FILED IN THE OFFICE OF

2014 MAR 17 PM 2:08

DEBRA BOWEN SECRETARY OF STATE

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2014-0307-01EE

For use by Office of Administrative Law (OAL) only

2014 MAR -7 AM 11:19

OFFICE OF ADMINISTRATIVE LAW

NOTICE | REGULATIONS

AGENCY WITH RULEMAKING AUTHORITY: California Health Benefit Exchange

AGENCY FILE NUMBER (If any):

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
☐ Notice re Proposed Regulatory Action ☐ Other			

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): 2014 Standard Benefit Plan Designs

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S): 2013-0910-03 E

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)

ADOPT: 6458

AMEND:

REPEAL:

TITLE(S): 10

3. TYPE OF FILING

- ☐ Regular Rulemaking (Gov. Code §11346)
- ☐ Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- ☐ Emergency (Gov. Code, §11346.1(b))
- ☐ Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- ☐ Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- ☒ Emergency Readopt (Gov. Code, §11346.1(h))
- ☐ File & Print
- ☐ Other (Specify) _____
- ☐ Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- ☐ Print Only

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- ☐ Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- ☒ Effective on filing with Secretary of State
- ☐ §100 Changes Without Regulatory Effect
- ☐ Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- ☐ Department of Finance (Form STD. 399) (SAM §6660)
- ☐ Fair Political Practices Commission
- ☐ State Fire Marshal
- ☐ Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Brandon Ross	(916) 228-8281		brandon.ross@covered.ca.gov

8. **I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.**

SIGNATURE OF AGENCY HEAD OR DESIGNEE: [signature]

DATE: 3/6/14

TYPED NAME AND TITLE OF SIGNATORY: Peter V. Lee, Executive Director

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

MAR 17 2014

Office of Administrative Law

Readopt Section 6458 to read:

Section 6458: 2014 Standard Benefit Plan Designs

(a) For plan year and calendar year 2014, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2014 Standard Benefit Plan Designs – FINAL, dated July 18, 2013, which is incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS 7/18/2013		Platinum Coinsurance Plan		Platinum Copay Plan	
Overall deductible		$0		$0	
Other deductibles for specific services					
	Medical	$0		$0	
	Brand Drugs	$0		$0	
	Dental	See Dental Design Below		See Dental Design Below	
Out-of-pocket limit on expenses		$4,000		$4,000	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20		$20	
	Specialist visit	$40		$40	
	Other practitioner office visit	$20		$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$20		$20	
	X-rays and Diagnostic Imaging	$40		$40	
	Imaging (CT/PET scans, MRIs)	10%		$150	
Drugs to treat illness or condition	Generic drugs	$5		$5	
	Preferred brand drugs	$15		$15	
	Non-preferred brand drugs	$25		$25	
	Specialty drugs	10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)	10%		$250	
	Physician/surgeon fees	10%			
	Emergency room services (waived if admitted)	$150		$150	
	Emergency medical transportation	$150		$150	
Need immediate attention	Urgent care	$40		$40	
Hospital stay	Facility fee (e.g., hospital room)	10%		$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20		$20	
	Mental/Behavioral health inpatient services	10%		$250 per day up to 5 days	
	Substance use disorder outpatient services	$20		$20	
	Substance use disorder inpatient services	10%		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	10%		$250 per day up to 5 days	
	Delivery and all inpatient services — Professional	10%			
Help recovering or other special health needs	Home health care	10%		$20	
	Rehabilitation services	$20		$20	
	Habilitation services	$20		$20	
	Skilled nursing care	10%		$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Dental Design Below		See Dental Design Below	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs),in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS 7/18/2013	Gold Coinsurance Plan	Gold Copay Plan
Overall deductible	$0	$0
Other deductibles for specific services:		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	See Dental Design Below	See Dental Design Below
Out-of-pocket limit on expenses	$6,350	$6,350

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30		$30	
	Specialist visit	$50		$50	
	Other practitioner office visit	$30		$30	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$30		$30	
	X-rays and Diagnostic imaging	$50		$50	
	Imaging (CT/PET scans, MRIs)	20%		$250	
Drugs to treat illness or condition	Generic drugs	$19		$19	
	Preferred brand drugs	$50		$50	
	Non-preferred brand drugs	$70		$70	
	Specialty drugs	20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)	20%		$800	
	Physician/surgeon fees	20%			
Need immediate attention	Emergency room services (waived if admitted)	$250		$250	
	Emergency medical transportation	$250		$250	
	Urgent care	$60		$60	
Hospital stay	Facility fee (e.g., hospital room)	20%		$600 per day up to 5 days	
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30		$30	
	Mental/Behavioral health inpatient services	20%		$600 per day up to 5 days	
	Substance use disorder outpatient services	$30		$30	
	Substance use disorder inpatient services	20%		$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	20%		$600 per day up to 5 days	
	Delivery and all inpatient services — Professional	20%			
Help recovering or other special health needs	Home health care	20%		$30	
	Rehabilitation services	$30		$30	
	Habilitation services	$30		$30	
	Skilled nursing care	20%		$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Dental Design Below		See Dental Design Below	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

Notes:

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Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

		Individual Only		Individual Only	
		Silver Coinsurance Plan		Silver Copay Plan	
Overall deductible		N/A		N/A	
Other deductibles for specific services					
	Medical	$2,000		$2,000	
	Brand Drugs	$250		$250	
	Dental	See Dental Design Below		See Dental Design Below	
Out-of-pocket limit on expenses		$6,350		$6,350	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45		$45	
	Specialist visit	$65		$65	
	Other practitioner office visit	$45		$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$45		$45	
	X-rays and Diagnostic Imaging	$65		$65	
	Imaging (CT/PET scans, MRIs)	20%	X	$250	
Drugs to treat illness or condition	Generic drugs	$19		$19	
	Preferred brand drugs	$50	X	$50	X
	Non-preferred brand drugs	$70	X	$70	X
	Specialty drugs	20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X	$250	X
	Emergency medical transportation	$250	X	$250	X
	Urgent care	$90		$90	
Hospital stay	Facility fee (e.g., hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45		$45	
	Mental/Behavioral health inpatient services	20%	X	20%	X
	Substance use disorder outpatient services	$45		$45	
	Substance use disorder inpatient services	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	20%	X	20%	X
	Delivery and all inpatient services — Professional	20%			
Help recovering or other special health needs	Home health care	20%		$45	
	Rehabilitation services	$45		$45	
	Habilitation services	$45		$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic				
	Dental Basic Services	See Dental Design Below		See Dental Design Below	
	Dental Restorative and Orthodontia Services				

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

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Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

	SHOP Only		SHOP Only	
	Silver Coinsurance Plan		Silver Copay Plan	
Overall deductible	N/A		N/A	
Other deductibles for specific services				
Medical	$1,500		$1,500	
Brand Drugs	$500		$500	
Dental	See Dental Design Below		See Dental Design Below	
Out-of-pocket limit on expenses	$6,350		$6,350	
Common Medical Event / Service Type	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic: Primary care visit to treat an injury or illness	$45		$45	
Specialist visit	$65		$65	
Other practitioner office visit	$45		$45	
Preventive care/ screening/ immunization	No cost share		No cost share	
Tests: Laboratory Tests	$45		$45	
X-rays and Diagnostic Imaging	$65		$65	
Imaging (CT/PET scans, MRIs)	20%	X	$250	
Drugs to treat illness or condition: Generic drugs	$19		$19	
Preferred brand drugs	$50	X	$50	X
Non-preferred brand drugs	$70	X	$70	X
Specialty drugs	20%	X	20%	X
Outpatient surgery: Facility fee (e.g., ASC)	20%		20%	
Physician/surgeon fees	20%		20%	
Emergency room services (waived if admitted)	$250	X	$250	X
Emergency medical transportation	$250	X	$250	X
Need immediate attention: Urgent care	$90		$90	
Hospital stay: Facility fee (e.g., hospital room)	20%	X	20%	X
Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs: Mental/Behavioral health outpatient services	$45		$45	
Mental/Behavioral health inpatient services	20%	X	20%	X
Substance use disorder outpatient services	$45		$45	
Substance use disorder inpatient services	20%	X	20%	X
Pregnancy: Prenatal care and preconception visits	No cost share		No cost share	
Delivery and all inpatient services — Hospital	20%	X	20%	X
Delivery and all inpatient services — Professional	20%			
Help recovering or other special health needs: Home health care	20%		$45	
Rehabilitation services	$45		$45	
Habilitation services	$45		$45	
Skilled nursing care	20%	X	20%	X
Durable medical equipment	20%		20%	
Hospice service	No cost share		No cost share	
Child needs dental or eye care: Eye exam (*deductible waived*)	0%		0%	
Glasses	1 pair per year		1 pair per year	
Dental check-up - Preventive and Diagnostic				
Dental Basic Services	See Dental Design Below		See Dental Design Below	
Dental Restorative and Orthodontia Services				

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

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Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

	SHOP Only Silver HSA Plan
Overall deductible	$1,500 Integrated Med/Rx
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See Dental Design Below
Out-of-pocket limit on expenses	$6,350

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		20%	X
	Specialist visit		20%	X
	Other practitioner office visit		20%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		20%	X
	Preferred brand drugs		20%	X
	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
Need immediate attention	Emergency room services (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g., hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	X
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		20%	X
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Rehabilitation services		20%	X
	Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		No cost share	X
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	
	Glasses		1 pair per year	
	Dental check-up - Preventive and Diagnostic		See Dental Design Below	
	Dental Basic Services			
	Dental Restorative and Orthodontia Services			

Notes:

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5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

		Individual Only		Individual Only	
		Silver Coinsurance Plan 100%-150% FPL		Silver Coinsurance Plan 150%-200% FPL	
Overall deductible		$0		N/A	
Other deductibles for specific services					
	Medical	$0		$500	
	Brand Drugs	$0		$50	
	Dental	See Dental Design Below		See Dental Design Below	
Out-of-pocket limit on expenses		$2,250		$2,250	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$3		$15	
	Specialist visit	$5		$20	
	Other practitioner office visit	$3		$15	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$3		$15	
	X-rays and Diagnostic Imaging	$5		$20	
	Imaging (CT/PET scans, MRIs)	10%		15%	X
Drugs to treat illness or condition	Generic drugs	$3		$5	
	Preferred brand drugs	$5		$15	X
	Non-preferred brand drugs	$10		$25	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	
	Physician/surgeon fees	10%		15%	
Need immediate attention	Emergency room services (waived if admitted)	$25		$75	X
	Emergency medical transportation	$25		$75	X
	Urgent care	$6		$30	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	X
	Physician/surgeon fee	10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$3		$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	$3		$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	10%		15%	X
	Delivery and all inpatient services — Professional	10%		15%	
Help recovering or other special health needs	Home health care	10%		15%	
	Rehabilitation services	$3		$15	
	Habilitation services	$3		$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic				
	Dental Basic Services	See Dental Design Below		See Dental Design Below	
	Dental Restorative and Orthodontia Services				

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

		Individual Only Silver Coinsurance Plan 200%-250% FPL
Overall deductible		N/A
Other deductibles for specific services		
	Medical	$1,500
	Brand Drugs	$250
	Dental	See Dental Design Below
Out-of-pocket limit on expenses		$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Other practitioner office visit		$40	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		$19	
	Preferred brand drugs		$30	X
	Non-preferred brand drugs		$50	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g., hospital room)		20%	X
	Physician/surgeon fee		20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care		20%	
	Rehabilitation services		$40	
	Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	
	Glasses		1 pair per year	
	Dental check-up - Preventive and Diagnostic		See Dental Design Below	
	Dental Basic Services			
	Dental Restorative and Orthodontia Services			

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs),in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

	Individual Only Silver Copay Plan 100%-150% FPL		Individual Only Silver Copay Plan 150%-200% FPL	
Overall deductible	$0		N/A	
Other deductibles for specific services				
Medical	$0		$500	
Brand Drugs	$0		$50	
Dental	See Dental Design Below		See Dental Design Below	
Out-of-pocket limit on expenses	$2,250		$2,250	
Common Medical Event / Service Type	**Member Cost Share**	**Deductible Applies**	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic: Primary care visit to treat an injury or illness	$3		$15	
Specialist visit	$5		$20	
Other practitioner office visit	$3		$15	
Preventive care/ screening/ immunization	No cost share		No cost share	
Tests: Laboratory Tests	$3		$15	
X-rays and Diagnostic Imaging	$5		$20	
Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition: Generic drugs	$3		$5	
Preferred brand drugs	$5		$15	X
Non-preferred brand drugs	$10		$25	X
Specialty drugs	10%		15%	X
Outpatient surgery: Facility fee (e.g., ASC)	10%		15%	
Physician/surgeon fees	10%		15%	
Emergency room services (waived if admitted)	$25		$75	X
Emergency medical transportation	$25		$75	X
Need immediate attention: Urgent care	$6		$30	
Hospital stay: Facility fee (e.g., hospital room) Physician/surgeon fee	10%		15%	X
Mental health, behavioral health, or substance abuse needs: Mental/Behavioral health outpatient services	$3		$15	
Mental/Behavioral health inpatient services	10%		15%	X
Substance use disorder outpatient services	$3		$15	
Substance use disorder inpatient services	10%		15%	X
Pregnancy: Prenatal care and preconception visits	No cost share		No cost share	
Delivery and all inpatient services: Hospital / Professional	10%		15%	X
Home health care	$3		$15	
Help recovering or other special health needs: Rehabilitation services	$3		$15	
Habilitation services	$3		$15	
Skilled nursing care	10%		15%	X
Durable medical equipment	10%		15%	
Hospice service	No cost share		No cost share	
Child needs dental or eye care: Eye exam (*deductible waived*)	0%		0%	
Glasses	1 pair per year		1 pair per year	
Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See Dental Design Below		See Dental Design Below	

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs),in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

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Covered California

2014 Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

		Individual Only Silver Copay Plan 200%-250% FPL	
Overall deductible		N/A	
Other deductibles for specific services			
	Medical	$1,500	
	Brand Drugs	$250	
	Dental	See Dental Design Below	
Out-of-pocket limit on expenses		$5,200	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible Applies**
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40	
	Specialist visit	$50	
	Other practitioner office visit	$40	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	$40	
	X-rays and Diagnostic Imaging	$50	
	Imaging (CT/PET scans, MRIs)	$250	
Drugs to treat illness or condition	Generic drugs	$19	
	Preferred brand drugs	$30	X
	Non-preferred brand drugs	$50	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X
	Emergency medical transportation	$250	X
	Urgent care	$80	
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services — Hospital Professional	20%	X
Help recovering or other special health needs	Home health care	$40	
	Rehabilitation services	$40	
	Habilitation services	$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice service	No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic		
	Dental Basic Services	See Dental Design Below	
	Dental Restorative and Orthodontia Services		

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs),in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individuals cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

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2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

	Bronze Plan	Bronze HSA Plan
Overall deductible	$5,000 integrated Med/Rx	$4,500 integrated Med/Rx
Other deductibles for specific services:		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	See Dental Design Below	See Dental Design Below
Out-of-pocket limit on expenses	$6,350	$6,350

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60	After 1st 3 non-preventive visits	40%	X
	Specialist visit	$70	X	40%	X
	Other practitioner office visit	$60	X	40%	X
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	30%	X	40%	X
	X-rays and Diagnostic Imaging	30%	X	40%	X
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
Drugs to treat illness or condition	Generic drugs	$19	X	40%	X
	Preferred brand drugs	$50	X	40%	X
	Non-preferred brand drugs	$75	X	40%	X
	Specialty drugs	30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)	30%	X	40%	X
	Physician/surgeon fees	30%	X	40%	X
Need immediate attention	Emergency room services (waived if admitted)	$300	X	40%	X
	Emergency medical transportation	$300	X	40%	X
	Urgent care	$120	After 1st 3 non-preventive visits	40%	X
Hospital stay	Facility fee (e.g., hospital room)	30%	X	40%	X
	Physician/surgeon fee	30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60	After 1st 3 non-preventive visits	40%	X
	Mental/Behavioral health inpatient services	30%	X	40%	X
	Substance use disorder outpatient services	$60	After 1st 3 non-preventive visits	40%	X
	Substance use disorder inpatient services	30%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	30%	X	40%	X
	Delivery and all inpatient services — Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care	30%	X	40%	X
	Rehabilitation services	30%	X	40%	X
	Habilitation services	30%	X	40%	X
	Skilled nursing care	30%	X	40%	X
	Durable medical equipment	30%	X	40%	X
	Hospice service	No cost share	X	No cost share	X
Child needs dental or eye care	Eye exam (*deductible waived*)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic				
	Dental Basic Services	See Dental Design Below		See Dental Design Below	
	Dental Restorative and Orthodontia Services				

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California
2014 Standard Benefit Plan Designs - FINAL
Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS 7/18/2013	Catastrophic Plan
Overall deductible	$6,350 integrated Med/Rx
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See Dental Design Below
Out-of-pocket limit on expenses	$6,350

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		0%	After 1st 3 non-preventive visits
	Specialist visit		0%	X
	Other practitioner office visit		0%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Generic drugs		0%	X
	Preferred brand drugs		0%	X
	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
Emergency care	Emergency room services (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
Need immediate attention	Urgent care		0%	After 1st 3 non-preventive visits
Hospital stay	Facility fee (e.g., hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		0%	After 1st 3 non-preventive visits
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	After 1st 3 non-preventive visits
	Substance use disorder inpatient services		0%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Rehabilitation services		0%	X
	Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		No cost share	X
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	
	Glasses		1 pair per year	
	Dental check-up - Preventive and Diagnostic			
	Dental Basic Services		See Dental Design Below	
	Dental Restorative and Orthodontia Services			

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs),in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

Covered California
Standard Pediatric Dental Essential Health Benefits Plan Design
For the 2014 Plan Year

Procedure Categories	DPPO High	DPPO Low	DHMO High	DHMO Low
	Plan Pays:		Enrollee Pays:	
Diagnostic & Preventive (D&P) X-rays, Exams, Cleanings Sealants	100%	100%	$0	$0
Office Visit	n/a	n/a	$0	$20
Basic Services - Basic Restorative	80%	50%	$40[3]	$95[3]
Major Services - Crowns & Casts, Prosthodontics, Endodontics, Periodontics, Oral Surgery	50%	50%	$365[4]	$365[4]
	Enrollee Pays:			
Orthodontics (Medically Necessary)	50%	50%	$1,000	$1,000
Deductible	$50 (not applied to D&P)	$60 (applied to all services)	None	None
Annual Maximum	None	None	None	None
OOP Maximum	$1,000	$1,000	$1,000	$1,000
Waiting Periods (Major & Ortho)	None	None	None	None
Actuarial Value (AV)	86%	72%	87%	72%

Notes:

1. Actuarial values are based on pediatric claims experience.
2. Orthodontics includes medically-necessary orthodontia only.
3. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.
4. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.
5. When more than one child is covered by a pediatric dental plan or policy, the policy/plan deductibles and out of pocket maximum amounts are equal to 2 times the individual values, however each individual child is responsible only for the single deductible and out of pocket maximum in a plan year.
6. Dental Exclusive Provider Organization (DEPO) products must conform to the DHMO Benefit Plan Design.