

**State of California  
Office of Administrative Law**

In re:  
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 6426

Amend sections:

Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY  
REGULATORY ACTION

Government Code Sections 11346.1 and  
11349.6

OAL File No. 2013-0322-02 E

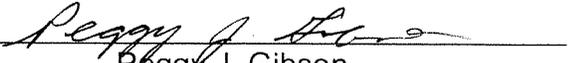
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The California Patient Protection and Affordable Care Act established the California Health Benefit Exchange (HBEX). HBEX is responsible for arranging and contracting with health insurance issuers to provide affordable, quality health insurance coverage to qualified individuals and qualified employers through the Exchange. HBEX must contract with health insurance issuers through a competitive selection process. This emergency rulemaking will provide the Standard Benefit Plan Designs established by HBEX. Bidders must submit either the co-pay or co-insurance plans in the Standard Benefit Plan Designs that are incorporated by reference into this rulemaking. Bidders must submit their plans and premium bids no later than 5:00 PM Pacific Time on April 2, 2013.

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 3/29/2013 and will expire on 9/26/2013. The Certificate of Compliance for this action is due no later than 9/25/2013.

Date: 3/29/2013

  
Peggy J. Gibson  
Senior Counsel

For: DEBRA M. CORNEZ  
Director

Original: Peter Lee  
Copy: Brandon Ross

# NOTICE PUBLICATION/REGULATIONS SUBMISSION

# EMERGENCY

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER <b>Z-</b>	REGULATORY ACTION NUMBER	EMERGENCY NUMBER <b>2013-0322-02E</b>
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ENDORSED FILED  
IN THE OFFICE OF

2013 MAR 29 PM 1:44

*Debra Bowen*  
DEBRA BOWEN  
SECRETARY OF STATE

For use by Office of Administrative Law (OAL) only	
NOTICE	REGULATIONS

2013 MAR 22 PM 3:34  
OFFICE OF ADMINISTRATIVE LAW

AGENCY WITH RULEMAKING AUTHORITY California Health Benefit Exchange	AGENCY FILE NUMBER (if any)
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### 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 <input type="checkbox"/> Notice re Proposed Regulatory Action <input type="checkbox"/> Other	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
<b>OAL USE ONLY</b>	ACTION ON PROPOSED NOTICE <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn	NOTICE REGISTER NUMBER	PUBLICATION DATE

### B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) Qualified Health Plans Standard Benefit Plan Designs	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
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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 6426
AMEND
TITLE(S) 10
REPEAL

3. TYPE OF FILING			
<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346) <input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4) <input checked="" type="checkbox"/> Emergency (Gov. Code, §11346.1(b))	<input type="checkbox"/> 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. <input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h)) <input type="checkbox"/> File & Print <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100) <input type="checkbox"/> 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)
<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a)) <input checked="" type="checkbox"/> Effective on filing with Secretary of State <input type="checkbox"/> §100 Changes Without Regulatory Effect <input type="checkbox"/> Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY
<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660) <input type="checkbox"/> Fair Political Practices Commission <input type="checkbox"/> State Fire Marshal <input type="checkbox"/> Other (Specify) _____

7. CONTACT PERSON Brandon Ross	TELEPHONE NUMBER (916) 323-3471	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) brandon.ross@hbex.ca.gov
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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 <i>Peter V. Lee</i>	DATE 3/22/13
TYPED NAME AND TITLE OF SIGNATORY Peter V. Lee, Executive Director	

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

MAR 28 2013

Office of Administrative Law

**Adopt Section 6426 to read:**

SECTION 6426: STANDARD BENEFIT PLAN DESIGNS

- (a) In responding to the Qualified Health Plan Solicitation, Bidders must use the Standard Benefit Plan Designs established by the Exchange. The Standard Benefit Plan Designs are identified in the Standard Benefit Plan Designs - FINAL, dated March 15, 2013, which is hereby incorporated by reference.
- (b) Bidders must submit either the co-pay or co-insurance plans in the Standard Benefit Plan Designs - FINAL, dated March 15, 2013, or a combination of the co-pay and co-insurance plans in order to offer coverage at all four levels of coverage and the catastrophic level of coverage in Bidders' proposed geographic service areas. However, Bidders for plans in the SHOP are prohibited from submitting bids for the Catastrophic coverage level. Bidders must submit their plans and premium bids pursuant to this section no later than 5:00 pm Pacific Time on April 2, 2013.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c)

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

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

3/15/2013

	Platinum Coinsurance Plan	Platinum Copay Plan
<b>Actuarial Value - Final AV Calculator</b>	88.1%	88.0%
<b>Overall deductible</b>	\$0	\$0
<b>Other deductibles for specific services</b>		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See 10 CCR § 6446(d)	See 10 CCR § 6446(d)
<b>Out-of-pocket limit on expenses</b>	\$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 (see footnote)	\$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%		\$250	
	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%		\$250 per day up to 5 days	
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	10%		\$250 per day up to 5 days	
	Hospital Professional	10%		\$250 per day up to 5 days	
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%	
Child needs dental or eye care	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Pediatric Dental Standard		See Pediatric Dental Standard	
	Dental Basic Services	Plan Design at 10 CCR § 6446(d)		Plan Design at 10 CCR § 6446(d)	
	Dental Restorative and Orthodontia Services				

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 postnatal visits or 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.

\* All cost sharing indicated, including the no cost sharing identified for preventive care and for prenatal and preconception services, is subject to federal rules issued pursuant to the Affordable Care Act and to applicable state statutes and regulations.

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

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

	Gold Coinsurance Plan	Gold Coplay Plan
3/15/2013		
<b>Actuarial Value - Final AV Calculator</b>	78.2%	78.0%
<b>Overall deductible</b>	\$0	\$0
<b>Other deductibles for specific services</b>		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See 10 CCR § 6446(d)	See 10 CCR § 6446(d)
<b>Out-of-pocket limit on expenses</b>	\$6,400	\$6,400

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 (see footnote)	\$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	\$20		\$20	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
Outpatient surgery	Specialty drugs	20%		20%	
	Facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%		\$600	
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%		\$600 per day up to 5 days	
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	20%		\$600 per day up to 5 days	
	Professional	20%		\$600 per day up to 5 days	
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%	
Child needs dental or eye care	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)		See Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)	
	Dental Basic Services	See Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)		See Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)	
	Dental Restorative and Orthodontia Services	See Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)		See Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)	

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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

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

3/15/2013

	Individual	Individual
	Silver Coinsurance Plan	Silver Copay Plan
Actuarial Value - Final AV Calculator	68.9%	68.5%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$250	\$250
Dental	See 10 CCR § 6446(d)	See 10 CCR § 6446(d)
Out-of-pocket limit on expenses	\$6,400	\$6,400

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 (see footnote)	\$45		\$45	
	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
Tests	Preventive care/ screening/ immunization	No cost share		No cost share	
	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	\$25		\$25	
	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
Need immediate attention	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	20%	X	20%	X
	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%	
Child needs dental or eye care	Hospice service	No cost share		No cost share	
	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 Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)		See Pediatric Dental Standard Plan Design at 10 CCR § 6446(d)	
	Dental Restorative and Orthodontia Services				

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 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 postnatal visits or 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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**Covered California**  
**Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

3/15/2013

	SHOP	SHOP
	Silver Coinsurance Plan	Silver Copay Plan
<b>Actuarial Value - Final AV Calculator</b>	69.9%	69.4%
<b>Overall deductible</b>	N/A	N/A
<b>Other deductibles for specific services</b>		
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
Dental	See 10 CCR § 6446(d)	See 10 CCR § 6446(d)
<b>Out-of-pocket limit on expenses</b>	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
<b>Visit to a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness (see footnote )	\$45		\$45	
	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
<b>Tests</b>	Laboratory Tests	\$45		\$45	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
<b>Drugs to treat illness or condition</b>	Generic drugs	\$25		\$25	
	Preferred brand drugs	\$50	X	\$50	X
	Non-preferred brand drugs	\$70	X	\$70	X
<b>Outpatient surgery</b>	Specialty drugs	20%	X	20%	X
	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
<b>Need immediate attention</b>	Emergency room services (waived if admitted)	\$250	X	\$250	X
	Emergency medical transportation	\$250	X	\$250	X
	Urgent care	\$90		\$90	
<b>Hospital stay</b>	Facility fee (e.g., hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
<b>Mental health, behavioral health, or substance abuse needs</b>	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
<b>Pregnancy</b>	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	20%	X	20%	X
	Professional	20%			
<b>Help recovering or other special health needs</b>	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	
<b>Child needs dental or eye care</b>	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Pediatric Dental Standard		See Pediatric Dental Standard	
	Dental Basic Services	Plan Design at 10 CCR § 6446(d)		Plan Design at 10 CCR § 6446(d)	
	Dental Restorative and Orthodontia Services	6446(d)		6446(d)	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 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 postnatal visits or 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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**Covered California**  
**Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

		Individual & SHOP
		Silver HSA Plan
3/15/2013		
Actuarial Value - Final AV Calculator		71.5%
Overall deductible		\$1500 integrated Med/Rx Ded
Other deductibles for specific services		
Medical		N/A
Brand Drugs		N/A
Dental		See 10 CCR § 6446(d)
Out-of-pocket limit on expenses		\$6,400

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 (see footnote)	20%	X
	Specialist visit	20%	X
	Other practitioner office visit	20%	X
Tests	Preventive care/ screening/ immunization	No cost share	
	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
	Emergency room services (waived if admitted)	20%	X
Need immediate attention	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% Professional 20%	X X
	Home health care	20%	X
Help recovering or other special health needs	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 Pediatric Dental Standard	
	Dental Basic Services	Plan Design at 10 CCR §	
	Dental Restorative and Orthodontia Services	6446(d)	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 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 postnatal visits or 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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**Covered California**  
**Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

3/15/2013

	Bronze Plan	Bronze HSA Plan
<b>Actuarial Value - Final AV Calculator</b>	60.4%	59.0%
<b>Overall deductible</b>	\$5000 integrated Med/Rx Ded	\$4500 integrated Med/Rx Ded
<b>Other deductibles for specific services</b>		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	See 10 CCR § 6446(d)	See 10 CCR § 6446(d)
<b>Out-of-pocket limit on expenses</b>	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
<b>Visit to a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness (see footnote)	\$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	
<b>Tests</b>	Laboratory Tests	30%	X	40%	X
	X-rays and Diagnostic Imaging	30%	X	40%	X
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
	Generic drugs	\$25	X	40%	X
<b>Drugs to treat illness or condition</b>	Preferred brand drugs	\$50	X	40%	X
	Non-preferred brand drugs	\$75	X	40%	X
	Specialty drugs	30%	X	40%	X
	Facility fee (e.g., ASC)	30%	X	40%	X
<b>Outpatient surgery</b>	Physician/surgeon fees	30%	X	40%	X
	Emergency room services (waived if admitted)	\$300	X	40%	X
	Emergency medical transportation	\$300	X	40%	X
	<b>Need immediate attention</b>	Urgent care	\$120	After 1st 3 non-preventive visits	40%
Facility fee (e.g., hospital room)		30%	X	40%	X
<b>Hospital stay</b>	Physician/surgeon fee	30%	X	40%	X
	Mental/Behavioral health outpatient services	\$60	After 1st 3 non-preventive visits	40%	X
<b>Mental health, behavioral health, or substance abuse needs</b>	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
	Prenatal care and preconception visits	No cost share		No cost share	
<b>Pregnancy</b>	Delivery and all inpatient services	30%	X	40%	X
	Hospital Professional	30%	X	40%	X
<b>Help recovering or other special health needs</b>	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
<b>Child needs dental or eye care</b>	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Pediatric Dental Standard		See Pediatric Dental Standard	
	Dental Basic Services	Plan Design at 10 CCR § 6446(d)		Plan Design at 10 CCR § 6446(d)	
	Dental Restorative and Orthodontia Services	6446(d)		6446(d)	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 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 postnatal visits or 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.

\* All cost sharing indicated, including the no cost sharing identified for preventive care and for prenatal and preconception services, is subject to federal rules issued pursuant to the Affordable Care Act and to applicable state statutes and regulations.

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

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

3/15/2013

	Catastrophic Plan
<b>Actuarial Value - Final AV Calculator</b>	60.4%
<b>Overall deductible</b>	\$6400 integrated Med/Rx Ded
<b>Other deductibles for specific services</b>	
Medical	N/A
Brand Drugs	N/A
Dental	See 10 CCR § 6446(d)
<b>Out-of-pocket limit on expenses</b>	\$6,400

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 (see footnote)	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
	Generic drugs	0%	X
Drugs to treat illness or condition	Preferred brand drugs	0%	X
	Non-preferred brand drugs	0%	X
	Specialty drugs	0%	X
	Facility fee (e.g., ASC)	0%	X
Outpatient surgery	Physician/surgeon fees	0%	X
	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
	Facility fee (e.g., hospital room)	0%	X
Hospital stay	Physician/surgeon fee	0%	X
	Mental/Behavioral health outpatient services	0%	After 1st 3 non-preventive visits
Mental health, behavioral health, or substance abuse needs	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
	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient services	0%	X
	Hospital 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	See Pediatric Dental Standard	
	Dental Basic Services	Plan Design at 10 CCR §	
	Dental Restorative and Orthodontia Services	6446(d)	

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