

October 31, 2014

ADVANCE NOTICE OF READOPTION OF EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give advance notice at least five working days of their intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file an Emergency Rulemaking package with the Office of Administrative Law (OAL) that establishes the 2015 Standard Benefit Plan Designs for health plan issuers and insurers in the individual and small group market both inside and outside of the Exchange. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Exchange plans to file the Emergency Rulemaking package with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the proposed regulations (also enclosed), they must be received by both the Exchange and the Office of Administrative Law within five calendar days of the Exchange's filing at OAL. Response to these comments is strictly at the Exchange's discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange Attn: Brandon Ross 1601 Exposition Blvd Sacramento, CA 95815

Office of Administrative Law 300 Capitol Mall, Suite 1250 Sacramento, CA 95815

Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulations with the Secretary of State, and the emergency regulations will become effective for two years from the initial date of adoption or until revised by the Board. This advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved.

You may also view the proposed regulatory language and Finding of Emergency on the Exchange's website at the following address: <u>http://hbex.coveredca.com/regulations/</u>.

If you have any questions concerning this Advance Notice, please contact Brandon Ross at (916) 228-8281.

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FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange finds that an emergency exists and that this proposed emergency regulation is necessary to address a situation that calls for immediate action to avoid serious harm to the public peace, health, safety or general welfare.

The Exchange has proceeded with diligence to comply with Government Code § 11346.1(e), and it has made substantial progress in that regard. The Exchange intends to make these emergency regulations permanent and has completed multiple steps in fulfilling the obligations required to seek a permanent rulemaking following this readoption. For example, the Exchange has finalized the Initial Statement of Reasons for the permanent rulemaking. The Exchange has been working with the Department of Finance to correctly identify whether this regulation is a "major regulation" and in completing the full fiscal and economic impact statement. The emergency rulemaking previously approved by OAL on May 21, 2014, will expire on November 18, 2014.

DEEMED EMERGENCY

The Exchange may "Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedures Act. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare." (Gov. Code, § 100504(a)(6)).

AUTHORITY AND REFERENCE

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

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

The California Health Benefit Exchange Standard Benefit Plan Designs - FINAL, dated April 17, 2014, will be incorporated by reference in the proposed regulations.

Summary of Existing Laws

Existing law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange. The Exchange 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. (Gov. Code, § 100500 et seq.) In order to provide health care coverage through the Exchange must contract with health insurance issuers through a competitive selection process based on uniform standards and criteria that

must be developed by the Exchange. (Gov. Code, §§ 100503, 100504). Existing law further allows give the Exchange the authority to standardize products that will be offered through the Exchange. (Gov. Code, § 100504(c)).

The proposed regulations will provide the public with the clear standards for how health insurance issuers must design critical components of their plans in order to be certified as a Qualified Health Plan. The regulations will ensure that all health plan issuers are on a level playing field and have an equal opportunity to be selected for participation in the Exchange. Additionally, these regulations will increase competition among the plans by allowing consumer to compare Qualified Health Plans side by side, which will allow health issuers to compete on price and value. Lastly, the regulations will increase transparency in the Exchange's process for selecting qualified health plans, which will result in greater consumer confidence in the Exchange.

The proposed regulations will provide the standards upon which health issuers will construct their health plans to be certified by the Exchange as Qualified Health Plans and offered through the Exchange to millions of Californians. The proposed regulations will specifically benefit millions of Californians by providing them with the ability to make a side by side comparison of Qualified Health Plans, which will allow them to make informed choices on which plan will provide the most value for themselves and their family members. The Exchange is the sole marketplace where Californians at certain income levels will be able to use federal tax credits to reduce the cost of their health insurance premiums and to purchase coverage that is eligible for federal subsidies that will reduce the cost-sharing requirements in their health plans. Without these proposed regulations, Californians would be unable to use federal tax subsidies for the purchase of Qualified Heath Plans that allow such a side by side comparison of benefits.

After an evaluation of current regulations, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. Further, the proposed regulations are not inconsistent or incompatible with any other regulations that address health plans outside of the Exchange.

MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

None.

LOCAL MANDATE

The Executive Director of the California Health Benefit Exchange has determined that this proposed regulatory action does not impose a mandate on local agencies or school districts.

FISCAL IMPACT ESTIMATES

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This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Part 7 (commencing with Section 17500) of Division 4 of the Government Code. This proposal does not impose other nondiscretionary cost or savings on local agencies.

COSTS OR SAVINGS TO STATE AGENCIES (Attached Form 399)

The proposal does not result in any costs or savings to any state agency.

COSTS OR SAVINGS IN FEDERAL FUNDING TO THE TO STATE (Attached Form 399)

The proposal does not result in any costs or savings in federal funding to the state.

Adopt Section 6460, which is all new regulation text to be added, to read:

SECTION 6460: 2015 STANDARD BENEFIT PLAN DESIGNS

(a) For plan year and calendar year 2015, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2015 Standard Benefit Plan Designs, dated April 17, 2014, 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)

2015 Standard Benefit Plan Designs

April 17, 2014



Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinu Coinsurand		Platinu Copay P	
•	e - AV Calculator	88.109		88.00%	
					•
	rall deductible al deductibles for specific services	\$0		\$0	
	Medical	\$0		\$0	
	Brand Drugs	\$0		\$0	
	Dental	\$0		\$0	
Individual Out-	ndividual Out–of–pocket maximum		0	\$4,000)
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
Health care	Primary care visit or non-specialist practitioner	\$20		\$20	
provider's	visit to treat an injury or illness	ψ20		ψ20	
office or					
clinic visit	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$20		\$20	
Tests	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat	Generic drugs	\$5		\$5	
illness or	Preferred brand drugs	\$15		\$15	
condition	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
Outpatient	Facility fee (e.g., ASC)	10%		\$250	
surgery	Physician/surgeon fees Emergency room services (waived if admitted)	10% \$150		¢150	
	Emergency room services (waived if admitted) Emergency medical transportation	\$150		\$150 \$150	
Need		ψισσ		ψ100	
immediate					
attention	Urgent care	\$40		\$40	
	Facility fee (e.g. hospital room)	10%		\$250 per day up	
Hospital stay	Physician/surgeon fee	10%		to 5 days	
	Martal/Dalastical backle and a distinct and is a	* ***		* ***	
	Mental/Behavioral health outpatient services	\$20		\$20	
Mental health, behavioral	Martal/Datasianal baskibing that an inco	100/		\$250 per day up	
health, or	Mental/Behavioral health inpatient services	10%		to 5 days	
substance					
abuse needs	Substance use disorder outpatient services	\$20		\$20	
		φ20		φ20	
	Substance use disorder inpatient services	10%		\$250 per day up	
				to 5 days	
	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	10%		\$250 per day up	
	services Professional	10%		to 5 days	
	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
Help	Outpatient Habilitation services	\$20	_	\$20	
recovering or other special	Skilled nursing care	10%		\$150 per day up	
health needs	Durable medical equipment	10%		to 5 days 10%	
	Hospice service	No cost share		No cost share	
Child eye	Eye exam	No cost share		No cost share	
care	1 pair of glasses per year (or contact lenses in lieu	No cost share		No cost share	
	of glasses) Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No gent change		No good change	
and	Sealants per Tooth	No cost share		No cost share	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental					
Basic	Amalgam Fill - 1 Surface	20%		\$25	
Services	Deat Canal Malar			* ***	
	Root Canal- Molar Gingiyectomy per Quad			\$300	
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or			\$150	
Major	Erupted	50%		\$65	
Services	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child					
	Medically necessary orthodontics	50%		\$1,000	

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of coinsurance Plan Copay Plan

Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator		Gold Coinsurance Plan 78.80%		Gold Copay Plan 78.60%	
	al deductibles for specific services				
	Medical	\$0		\$0	
	Brand Drugs Dental	\$0 \$0		\$0 \$0	
Individual Out-	–of–pocket maximum	\$6,25	0	\$6,250)
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$30		\$30	
clinic visit	Specialist visit	\$50		\$50	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$30		\$30	
Tests	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat	Generic drugs	\$15		\$15	
illness or	Preferred brand drugs Non-preferred brand drugs	\$50 \$70		\$50 \$70	
condition	Specialty drugs	\$70		\$70 20%	
Outpatient	Facility fee (e.g., ASC)	20%			
surgery	Physician/surgeon fees	20%		\$600	
5	Emergency room services (waived if admitted)	\$250		\$250	
	Emergency medical transportation	\$250		\$250	
Need immediate attention	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%		\$600 per day up to 5 days	
Mental health,	Mental/Behavioral health outpatient services	\$30		\$30	
behavioral	Mental/Behavioral health inpatient services	20%		\$600 per day up to 5 days	
health, or substance abuse needs	Substance use disorder outpatient services	\$30		\$30	
	Substance use disorder inpatient services	20%		\$600 per day up to 5 days	
D	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	20%		\$600 per day up	
	services Professional	20%		to 5 days	
	Home health care	20%		\$30	
Holm	Outpatient Rehabilitation services	\$30		\$30	
Help recovering or	Outpatient Habilitation services	\$30		\$30 \$300 per day up	
other special	Skilled nursing care	20%		to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child eye	Eye exam	No cost share		No cost share	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
	Oral Exam				
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share	
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar			\$300	
Child Dental	Gingivectomy per Quad			\$150	
Major	Extraction- Single Tooth Exposed Root or	50%		\$65	
Services	Erupted				
	Extraction- Complete Bony Porcelain with Metal Crown			\$160 \$300	
				ψυυυ	
Child					

2015 Standard Benefit Plan Designs 10.0 EHB

Date: April 17, 2014

Summary of	Benefits and Coverage		Individ	ual	Individu	ual
	hare amounts describe the En	rollee's out of	Silve		Silver	r
pocket costs.			Coinsurance Plan		Copay Plan	
Actuarial Value	e - AV Calculator		70.309	%	69.90%	6
	rall deductible		N/A		N/A	
Other individu	al deductibles for specific se Medical	ervices	\$2,00	0	\$2,000)
	Brand Drugs		\$250		\$250	
Individual Out	Dental		\$0 \$6.25	0	\$0)
Individual Out-	–of–pocket maximum		\$6,25	0	\$6,250	J
0						
Common Medical Event	Service Typ	N O	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's	Primary care visit or non-spectivisit to treat an injury or illness		\$45		\$45	
office or	Consider the state		фо <u>г</u>			
clinic visit	Specialist visit		\$65		\$65	
	Preventive care/ screening/ in	nmunization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRI		\$65 20%	X	\$65 \$250	
	Generic drugs	3/	20% \$15		\$250 \$15	
Drugs to treat	Preferred brand drugs		\$50	Х	\$50	Х
llness or condition	Non-preferred brand drugs		\$70	X	\$70	X
	Specialty drugs		20%	Х	20%	Х
Outpatient	Facility fee (e.g., ASC)		20%		20%	
surgery	Physician/surgeon fees	1	20%		20%	
	Emergency room services (wa Emergency medical transporta		\$250 \$250	X X	\$250 \$250	X
Need	Emergency medical transport	alion	\$250	~	¢250	~
immediate						
attention	Urgent care		\$90		\$90	
	Facility fee (e.g. hospital room	ו)	20%	Х	20%	х
Hospital stay	Physician/surgeon fee		20%		20%	
Mental health.	Mental/Behavioral health outp	atient services	\$45		\$45	
behavioral health, or	Mental/Behavioral health inpatient services		20%	х	20%	х
substance abuse needs	Substance use disorder outpa	tient services	\$45		\$45	
	Substance use disorder inpati	ent services	20%	х	20%	х
Pregnancy	Prenatal care and preconcept Delivery and all inpatient		No cost share	X	No cost share	
	services	Hospital Professional	20%	^	20%	Х
	Home health care		20%		\$45	
	Outpatient Rehabilitation serv		\$45		\$45	
Help	Outpatient Habilitation service	S	\$45		\$45	
recovering or other special	Skilled nursing care		20%	х	20%	х
health needs	Durable medical equipment		20%		20%	
	Hospice service					
			No cost share		No cost share	
Child eye	Eye exam 1 pair of glasses per year (or o	contact longes in list	No cost share		No cost share	
care	of glasses)	Soniaol ienses in iieu	No cost share		No cost share	
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		No cost share		No cost share	
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Amalgam Fill - 1 Surface		20%		\$25	
Basic					\$300	
Basic	Root Canal- Molar				\$300	
Basic Services	Root Canal- Molar Gingivectomy per Quad					
Basic Services Child Dental		sed Root or	50%			
Basic Services Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo Erupted	osed Root or	50%		\$65	
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Expo Erupted Extraction- Complete Bony	osed Root or	50%		\$65 \$160	
Basic Services Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo Erupted	used Root or	50%		\$65	

Summary of Benefits and Coverage		SHOP			IOP		
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Coinsurance Plan		Silver Copay Plan			
	e - AV Calculator		71.50%		71.00%		
	rall deductible			N/A	Ν	/A	
	al deductibles for specific	services				//A	
	Medical			1,500		500	
	Brand Drugs Dental		9	\$500 \$0		500 50	
ndividual Out-	–of–pocket maximum		\$6	6,250		250	
Common			Member Cost		Member Cost		
Medical Event	Service T	/ре	Share	Deductible Applies	Share	Deductible Applie	
lealth care provider's	Primary care visit or non-spe visit to treat an injury or illne		\$45		\$45		
office or linic visit	Specialist visit		\$65		\$65		
anno visit	Preventive care/ screening/	immunization	No cost share		No cost share		
		ininianization					
ests	Laboratory Tests X-rays and Diagnostic Imagi	na	\$45 \$65		\$45 \$65		
	Imaging (CT/PET scans, MF		20%	Х	\$250		
Drugs to treat	Generic drugs		\$15		\$15		
liness or	Preferred brand drugs		\$50	X	\$50	X	
ondition	Non-preferred brand drugs Specialty drugs		\$70	<u>Х</u> Х	\$70 20%	X	
Outpatient	Facility fee (e.g., ASC)		20% 20%		20%	X	
surgery	Physician/surgeon fees		20%		20%		
	Emergency room services (N	waived if admitted)	\$250	Х	\$250	Х	
lood	Emergency medical transpo		\$250	Х	\$250	Х	
leed mmediate Ittention	Urgent care		\$90		\$90		
	Facility fee (e.g. hospital roc	m)	20%	Х	200/	×	
lospital stay	Physician/surgeon fee		20%		20%	Х	
Aental health, behavioral	Mental/Behavioral health ou		\$45	Y	\$45	v	
ealth, or	Mental/Behavioral health inp	alient services	20%	X	20%	X	
ubstance buse needs	Substance use disorder out	patient services	\$45		\$45		
	Substance use disorder inpa	atient services	20%	Х	20%	х	
	Prenatal care and preconce	otion visits	No cost share		No cost share		
regnancy	Delivery and all inpatient	Hospital	20%	Х	20%	Х	
	services	Professional	20%			~	
	Home health care Outpatient Rehabilitation se	Nices	20% \$45		\$45 \$45		
lelp	Outpatient Renabilitation servi		\$45 \$45		\$45 \$45		
ecovering or				v		v	
ther special	Skilled nursing care		20%	X	20%	Х	
ealth needs	Durable medical equipment		20%		20%	_	
	Hospice service		No cost share		No cost share	1	
Child eye	Eye exam		No cost share		No cost share		
are	1 pair of glasses per year (o of glasses)	r contact lenses in lieu	No cost share		No cost share		
	Oral Exam						
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray						
	Sealants per Tooth		No cost share		No cost share		
-							
nd	Topical Fluoride Application					1	
nd Preventive	Topical Fluoride Application Space Maintainers - Fixed						
nd Preventive Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%		\$25		
nd Preventive Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar		20%		\$300		
Ind Preventive Child Dental Basic Services Child Dental	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad				\$300 \$150		
Ind Preventive Child Dental Basic Services Child Dental Major	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar		20%		\$300		
and Preventive Child Dental Basic Services Child Dental Major	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exp Erupted Extraction- Complete Bony				\$300 \$150		
Child Dental Basic Services Child Dental Major Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exp Erupted				\$300 \$150 \$65		

2015 Standard Benefit Plan Designs 10.0 EHB

Date: April 17, 2014

	Benefits and Coverag hare amounts describe the E		SHO	
ocket costs.			HSA P	
Actuarial Value	e - AV Calculator		71.60	%
	rall deductible		\$1,500 integrated	Med/Rx Ded
Other individua	al deductibles for specific :	services		
	Medical Brand Drugs		N/A N/A	
	Dental		N/A	
ndividual Out-	-of-pocket maximum		\$6,25	50
Common Medical Event	Service Ty	/pe	Member Cost Share	Deductible Applies
Health care provider's	Primary care visit or non-spe visit to treat an injury or illne	ecialist practitioner	20%	х
office or clinic visit	Specialist visit		20%	Х
	Preventive care/ screening/	immunization	No cost share	
		ininunization		
Tooto	Laboratory Tests	ng	20%	X
Tests	X-rays and Diagnostic Imagi Imaging (CT/PET scans, MF	-	20% 20%	X X
	Generic drugs		20%	X
Drugs to treat	Preferred brand drugs		20%	X
Ilness or condition	Non-preferred brand drugs		20%	X
onution	Specialty drugs		20%	Х
Dutpatient	Facility fee (e.g., ASC)		20%	Х
surgery	Physician/surgeon fees		20%	Х
	Emergency room services (v		20%	Х
Veed	Emergency medical transpo	rtation	20%	X
mmediate attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital roo	m)	20%	Х
nospital stay	Physician/surgeon fee		20%	X
Mental health, behavioral	Mental/Behavioral health outpatient services		20%	x
health, or	menta/Denavioral ricatin inp		2078	~
substance abuse needs	Substance use disorder outpatient services		20%	х
	Substance use disorder inpa	atient services	20%	х
	Prenatal care and preconce	otion visits	No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	Х
	Home health care		20%	X
	Outpatient Rehabilitation ser		20%	<u> </u>
Help	Outpatient Habilitation service	ces	20%	X
ecovering or other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	Х
	Hospice service		No cost share	X
Child eye	Eye exam		No cost share	
care	1 pair of glasses per year (or of glasses)	r contact lenses in lieu	No cost share	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray		No cost share	
and Preventive	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
	Root Canal- Molar			
Child Dental	Gingivectomy per Quad	Dest st		
Major	Extraction- Single Tooth Exp	oosed Root or	50%	
Services	Erupted Extraction- Complete Bony			
	Porcelain with Metal Crown			
	Porcelain with Metal Crown			

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Coinsur 100%-150	% FPL	Silver Coinsur 150%-2009	% FPL	
Actuarial Value	e - AV Calculator		94.80	%	88.00	%
Individual Ove	rall deductible		\$0		N/A	
Other individua	al deductibles for specific s	ervices	0.1		¢ЕОС	,
	Medical Brand Drugs		\$0 \$0		\$500 \$50	
	Dental		\$0		\$30	
ndividual Out–of–pocket maximum		\$2,25	0	\$2,25	0	
Common Medical Event	Service Ty	pe	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-spervisit to treat an injury or illnes		\$3		\$15	
clinic visit	Specialist visit		\$5		\$20	
	Preventive care/ screening/ ir	nmunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests	X-rays and Diagnostic Imagin		\$5		\$20	
	Imaging (CT/PET scans, MR	s)	10%		15%	Χ
Drugs to treat	Generic drugs		\$3		\$5	X
Ilness or	Preferred brand drugs		\$5 \$10		\$15	X
condition	Non-preferred brand drugs Specialty drugs		\$10 10%		\$25 15%	X
	Facility fee (e.g., ASC)		10%		15%	
surgery	Physician/surgeon fees		10%		15%	
	Emergency room services (w	aived if admitted)	\$25		\$75	X
	Emergency medical transport		\$25		\$75	X
Need immediate attention	Urgent care		\$6		\$30	
	Facility fee (e.g. hospital roon	n)	10%		15%	Х
Hospital stay	Physician/surgeon fee	/	10%		15%	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Mental health,	Mental/Behavioral health outpatient services Mental/Behavioral health inpatient services Substance use disorder outpatient services		\$3		\$15	
behavioral health, or substance			10%		15%	Х
abuse needs			\$3		\$15	
	Substance use disorder inpat	ient services	10%		15%	х
Pregnancy	Prenatal care and preconcep		No cost share		No cost share	
	Delivery and all inpatient	Hospital	10%		15%	X
	services Home health care	Professional	10%		15%	
	Outpatient Rehabilitation serv	vices	10% \$3		15% \$15	
Help	Outpatient Habilitation service		\$3		\$15	
recovering or						
other special	Skilled nursing care		10%		15%	Х
health needs	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam		No cost share		No cost share	
Child eye	1 pair of glasses per year (or	contact lenses in lieu				
care	of glasses)		No cost share		No cost share	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray					
and	Sealants per Tooth		No cost share		No cost share	
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
	Root Canal- Molar					
Child Dental	Gingivectomy per Quad					
Child Dental Major	Extraction- Single Tooth Expo	osed Root or	50%		50%	
Services	Erupted		0070		0070	
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child	Medically necessary orthodor	otice	50%		50%	

Summary of Benefits and Coverage

pocket costs.	hare amounts describe the En	rollee's out of	Silver Coinsur 200%-250	% FPL
Actuarial Value	e - AV Calculator		rounded up t	0 74.0%
Individual Ove	rall deductible		N/A	
Other individua	al deductibles for specific se	ervices	.	•
	Medical Brond Drugo		\$1,60	
	Brand Drugs Dental		\$250 \$0)
Individual Out-	-of-pocket maximum		\$5,20	0
Common Medical Event	Service Typ	be	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-spec visit to treat an injury or illness		\$40	
clinic visit	Specialist visit		\$50	
	Preventive care/ screening/ in	nmunization	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imagin	q	\$50	
	Imaging (CT/PET scans, MRI		20%	Х
Drugs to treat	Generic drugs		\$15	
illness or	Preferred brand drugs		\$35	X
condition	Non-preferred brand drugs		\$60	X
Outpatient	Specialty drugs Facility fee (e.g., ASC)		20% 20%	X
surgery	Physician/surgeon fees		20%	
	Emergency room services (wa	aived if admitted)	\$250	Х
	Emergency medical transport	ation	\$250	Х
Need immediate attention	Urgent care	\$80		
	Facility fee (e.g. hospital room	ו)	20%	Х
Hospital stay	Physician/surgeon fee		20%	
Mental health,	Mental/Behavioral health outp	\$40		
behavioral health, or substance	Mental/Behavioral health inpa	20%	X	
abuse needs	Substance use disorder outpa	\$40		
	Substance use disorder inpat	ient services	20%	X
Pregnancy	Prenatal care and preconcept		No cost share	X
	Delivery and all inpatient services	Hospital Professional	20% 20%	X
	Home health care	FIDIESSIDITAL	20%	
	Outpatient Rehabilitation serv	ices	\$40	
Help	Outpatient Habilitation service	es	\$40	
recovering or	Skilled nursing care		20%	х
other special				~
health needs	Durable medical equipment		20%	
	Hospice service		No cost share	
	Eye exam		No cost share	
Child eye care	1 pair of glasses per year (or of glasses)	contact lenses in lieu	No cost share	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No cost share	
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
	Root Canal- Molar			
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo Erupted	osed Root or	50%	
Services	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child	Medically necessary orthodon	tics	50%	

Summary of Benefits and Coverage

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

 100%-150% FPL
 150%-200% FPL

pocket costs.	hare amounts describe the Er	indice 3 out of	Silver Cop 100%-150		Silver Cop 150%-200	-
Actuarial Value	Actuarial Value - AV Calculator		94.90	%	88.00%	
Individual Over	rall deductible		\$0		N/A	•
	al deductibles for specific s	ervices	<i>\$</i>			•
	Medical		\$0		\$50	0
	Brand Drugs		\$0		\$50	
	Dental		\$0	0	\$0	
Individual Out-	-of–pocket maximum		\$2,25	50	\$2,2	50
Common Medical Event	Service Ty	pe	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-spe visit to treat an injury or illnes Specialist visit		\$3 \$5		\$15 \$20	
chine visit	Preventive care/ screening/ in	mmunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
	X-rays and Diagnostic Imagir	a	\$5		\$20	
	Imaging (CT/PET scans, MR		\$50		\$100	
	Generic drugs	-/	\$3		\$5	
Drugs to treat	Preferred brand drugs		\$5		\$15	Х
liness or	Non-preferred brand drugs		\$10		\$25	X
condition	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	
-	Physician/surgeon fees		10%		15%	
	, ,					V
	Emergency room services (w	,	\$25		\$75	X
Need	Emergency medical transport	ation	\$25		\$75	Х
immediate	Urgent care		\$6		\$30	
Hospital stav	Facility fee (e.g. hospital roor Physician/surgeon fee	n)	10%		15%	х
Mental health,	Mental/Behavioral health out		\$3		\$15	
health, or	Mental/Behavioral health inpa	atient services	10%		15%	Х
substance abuse needs	Substance use disorder outpatient services		\$3		\$15	
	Substance use disorder inpa	tient services	10%		15%	х
Pregnancy	Prenatal care and preconcep	tion visits	No cost share		No cost share	
	Delivery and all inpatient services	Hospital Professional	10%		15%	Х
	Home health care		\$3		\$15	
	Outpatient Rehabilitation service		\$3		\$15	
	Outpatient Habilitation servic	es	\$3		\$15	
ecovering or	Skilled nursing care		10%		15%	х
other special	3					~
nealth needs	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye	Eye exam		No cost share		No cost share	
care	1 pair of glasses per year (or of glasses)	contact lenses in lieu	No cost share		No cost share	
Child Dental Diagnostic and	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No cost share		No cost share	
Child Dental Basic Services	Amalgam Fill - 1 Surface		\$25		\$25	
	Root Canal- Molar		\$300		\$300	
Child Dental	Gingivectomy per Quad		\$150		\$150	
Child Dental Major	Extraction- Single Tooth Exp	osed Root or	¢ee			
Services	Erupted		\$65		\$65	
	Extraction- Complete Bony		\$160		\$160	
	Porcelain with Metal Crown		\$300		\$300	
Child	Medically necessary orthodor		\$1,000		\$1,000	

Summary of Benefits and Coverage

Member Cost S pocket costs.	hare amounts describe the En	rollee's out of	Silver Copa 200%-250	
	e - AV Calculator		73.50	
ndividual Ove	rall deductible		N/A	
	al deductibles for specific s	ervices		
	Medical		\$1,60	0
	Brand Drugs		\$250)
ndividual Out-	Dental -of–pocket maximum		\$0 \$5,20	0
individual Out			φ0,20	
Common Medical Event	Service Ty)e	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-spective visit to treat an injury or illness		\$40	
clinic visit				
	Preventive care/ screening/ ir	nmunization	No cost share	
Fests	Laboratory Tests X-rays and Diagnostic Imagin	a	\$40 \$50	
10313	Imaging (CT/PET scans, MRI		\$250	
	Generic drugs		\$15	
Drugs to treat Ilness or	Preferred brand drugs		\$35	Х
condition	Non-preferred brand drugs		\$60	Х
	Specialty drugs		20%	X
Outpatient	Facility fee (e.g., ASC)		20%	
surgery	Physician/surgeon fees Emergency room services (wa	aived if admitted)	20% \$250	X
	Emergency room services (was Emergency medical transport		\$250 \$250	X
Need mmediate attention	Urgent care		\$80	~~~~
Hospital stay	Facility fee (e.g. hospital roon Physician/surgeon fee	20%	x	
Mental health,	Mental/Behavioral health outp	\$40		
behavioral health, or substance	Mental/Behavioral health inpa	20%	Х	
abuse needs	Substance use disorder outpa	\$40		
	Substance use disorder inpat	ient services	20%	х
Pregnancy	Prenatal care and preconcept Delivery and all inpatient	ion visits Hospital	No cost share	
	services	Professional	20%	Х
	Home health care		\$40	
	Outpatient Rehabilitation serv		\$40	
Help	Outpatient Habilitation service	es	\$40	
ecovering or other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	
	Hospice service		No cost share	
	· · ·			
Child eye	Eye exam 1 pair of glasses per year (or o	contact lensos in lieu	No cost share	
care	of glasses)	contact tenses in heu	No cost share	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No cost share	_
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		\$25	
	Root Canal- Molar		\$300	
Child Dental	Gingivectomy per Quad		\$150	
Major	Extraction- Single Tooth Expo	osed Root or	\$65	
Services	Erupted Extraction- Complete Bony			
	Porcelain with Metal Crown		\$160 \$300	
Child				
Child Orthodontics	Medically necessary orthodor	tics	\$1,000	

Summary of Benefits and Coverage

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

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze HSA Plan		
Actuarial Value	e - AV Calculator	60.60%		59.40%		
Individual Ove	rall deductible	\$5,000 integrate	ed Med/Rx Ded	\$4,500 integrat	ed Med/Rx	
	al deductibles for specific services	<i>•••</i> ,••••g				
	Medical	N/		N/A		
	Brand Drugs	N/		N/A		
Individual Out	Dental –of–pocket maximum	\$0 \$6,2		\$6,25		
		φ0,2		\$0,20		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$60	After 1st three non- preventive visits	40%	х	
clinic visit	Specialist visit	\$70	X	40%	Х	
	Preventive care/ screening/ immunization	No cost share		No cost share		
	Laboratory Tests	30%	X	40%	Х	
Tests	X-rays and Diagnostic Imaging	30%	Х	40%	Х	
	Imaging (CT/PET scans, MRIs)	30%	Х	40%	Х	
Drugs to treat	Generic drugs	\$15	Х	40%	Х	
illness or	Preferred brand drugs	\$50	X	40%	Х	
condition	Non-preferred brand drugs	\$75	X	40%	Х	
	Specialty drugs	30%	<u> </u>	40%	X	
Outpatient	Facility fee (e.g., ASC)	30%	X	40%	X	
surgery	Physician/surgeon fees	30%	X	40%	X	
	Emergency room services (waived if admitted) Emergency medical transportation	\$300 \$300	X	40% 40%	X	
Need immediate attention	Urgent care	\$120	After 1st three non- preventive visits	40%	x	
	Facility fee (e.g. hospital room)	30%	X	40%	Х	
Hospital stay	Physician/surgeon fee	30%	Х	40%	Х	
Mental health.	Mental/Behavioral health outpatient services	\$60	After 1st three non- preventive visits	40%	x	
behavioral health, or	Mental/Behavioral health inpatient services	30%	х	40%	х	
substance abuse needs	Substance use disorder outpatient services	\$60	After 1st three non- preventive visits	40%	х	
	Substance use disorder inpatient services	30%	x	40%	Х	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share		
	Delivery and all inpatient Hospital	30%	X	40%	X	
	Services Professional	30%	X X	40%	X X	
	Home health care Outpatient Rehabilitation services	30% \$60	X	40% 40%	X	
Help	Outpatient Renabilitation services	\$60	X	40%	X	
recovering or						
other special	Skilled nursing care	30%	х	40%	Х	
health needs	Durable medical equipment	30%	Х	40%	Х	
	Hospice service	No cost share	х	No cost share	х	
Child eye	Eye exam	No cost share		No cost share		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share		
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share		
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		20%		
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	50%		50%		
Child Orthodontics	Medically necessary orthodontics	50%		50%		

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	Benefits and Coverage		
	hare amounts describe the Enrollee's out of	Catastroph	ic Plan
Actuarial Value	e - AV Calculator		
Individual Ove	rall deductible	\$6,600 integrated	I Med/Rx De
Other individu	al deductibles for specific services		
	Medical Brand Drugs	N/A N/A	
	Dental	N/A	
Individual Out-	-of-pocket maximum	\$6,60	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	. 0%	After 1st three non- preventive visits
clinic visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No cost share	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	<u>X</u>
Drugs to treat	Generic drugs Preferred brand drugs	0% 0%	X
illness or	Non-preferred brand drugs	0%	X
condition	Specialty drugs	0%	X
Outpatient	Facility fee (e.g., ASC)	0%	Х
surgery	Physician/surgeon fees	0%	X
	Emergency room services (waived if admitted) Emergency medical transportation	0%	X
Need immediate attention	Urgent care	0%	After 1st three non preventive visits
Hospital stay	Facility fee (e.g. hospital room)	0%	Х
Mental health.	Physician/surgeon fee Mental/Behavioral health outpatient services	0%	X After 1st three non preventiv visits
behavioral health, or	Mental/Behavioral health inpatient services	0%	х
substance abuse needs	Substance use disorder outpatient services	0%	After 1st three non preventiv visits
	Substance use disorder inpatient services	0%	х
Programa	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital	0%	X
	services Professional Home health care	0%	X X
	Outpatient Rehabilitation services	0%	X
Help	Outpatient Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	х
health needs	Durable medical equipment	0%	Х
	Hospice service	No cost share	X
Child eye	Eye exam	No cost share	
care	1 pair of glasses per year (or contact lenses in li of glasses)	eu No cost share	х

Oral Exam

Child Dental Diagnostic

and Preventive

Child Dental

Child Dental Major Services

Child Orthodontics

Basic Services Preventive - Cleaning Preventive - X-ray

Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed

Amalgam Fill - 1 Surface

Extraction- Complete Bony Porcelain with Metal Crown

Medically necessary orthodontics

Gingivectomy per Quad Extraction- Single Tooth Exposed Root or

Root Canal- Molar

Erupted

No cost share

20%

50%

50%

Х

X X

Х

X X

Х

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Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the carrier pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of \$2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
- Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
- 5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 6) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month.
- 7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
- 8) For drugs to treat an illness or condition the copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.
- 9) For the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental benefit design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to copays for non-preventive child dental benefits.



Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator		Platinum Coinsurance Plan 88.10%		Platinum Copay Plan 88.00%		
				/0		
	rall deductible		\$0		\$0	
Other Individu	al deductibles for specific services Medical	_	\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		\$0	0	\$0	`
	–of–pocket maximum	_	\$4,00	0	\$4,000)
Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist practivisit to treat an injury or illness	itioner	\$20		\$20	
clinic visit	Specialist visit		\$40		\$40	
	Preventive care/ screening/ immunization	'n	No cost share		No cost share	
	Laboratory Tests		\$20		\$20	
Tests	X-rays and Diagnostic Imaging		\$40		\$40	
	Imaging (CT/PET scans, MRIs)		10%		\$150	
Drugs to treat	Generic drugs Preferred brand drugs		\$5 \$15		\$5 \$15	
illness or	Non-preferred brand drugs		\$25		\$25	
condition	Specialty drugs		10%		10%	
Outpatient	Facility fee (e.g., ASC)		10%		\$250	
surgery	Physician/surgeon fees		10%			
	Emergency room services (waived if adm	mitted)	\$150		\$150	
Need	Emergency medical transportation		\$150		\$150	
immediate attention	Urgent care		\$40		\$40	
	Facility fee (e.g. hospital room)		10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days	
Mental health,	Mental/Behavioral health outpatient serv	vices	\$20		\$20	
behavioral	Mental/Behavioral health inpatient service	ces	10%		\$250 per day up to 5 days	
health, or substance abuse needs	Substance use disorder outpatient servic	ces	\$20		\$20	
	Substance use disorder inpatient service	es	10%		\$250 per day up to 5 days	
	Prenatal care and preconception visits		No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	_	10%		\$250 per day up	
	services Professio	nal	10%		to 5 days	
	Home health care		10%		\$20	
	Outpatient Rehabilitation services		\$20		\$20	
Help	Outpatient Habilitation services		\$20		\$20	
recovering or other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
	Hospice service		No cost share		No cost share	
Child eye	Eye exam		No cost share		No cost share	
care	1 pair of glasses per year (or contact lense of glasses)	es in lieu	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered		Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar				Not Covered	
Child Dental	Gingivectomy per Quad				Not Covered	
Major	Extraction- Single Tooth Exposed Root of	or	Not Covered		Not Covered	
Services	Erupted Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of Coinsurance Plan Copay Plan

Member Cost S pocket costs.	hare amounts describe the E	nrollee's out of	Gold Coinsuranc		Gold Copay P	lan
Actuarial Value - AV Calculator		78.80%		78.60%		
Individual Ove	rall deductible		\$0		\$0	
	al deductibles for specific s	services	ψυ			
	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		\$0	-	\$0	
Individual Out-	-of-pocket maximum		\$6,25	0	\$6,250)
Common Medical Event	Service Ty	IDA	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit or non-spe visit to treat an injury or illne	ecialist practitioner	\$30		\$30	
provider's office or		55				
clinic visit	Specialist visit Preventive care/ screening/ i	immunization	\$50 No cost share		\$50 No cost share	
	Laboratory Tests		\$30		\$30	
Tests	X-rays and Diagnostic Imagi	ng	\$50		\$50	
	Imaging (CT/PET scans, MR	ls)	20%		\$250	
	Generic drugs		\$15		\$15	
Drugs to treat illness or	Preferred brand drugs		\$50		\$50	
	Non-preferred brand drugs		\$70		\$70	
condition	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC)		20%			
surgery	Physician/surgeon fees		20%		\$600	
	Emergency room services (v	vaived if admitted)	\$250		\$250	
	Emergency medical transpor		\$250		\$250	
Need immediate		lation	φ230		φ230	
attention	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g. hospital roo	m)	20%		\$600 per day up	
iospital stay	Physician/surgeon fee		20%		to 5 days	
Mental health,	Mental/Behavioral health out	patient services	\$30		\$30	
behavioral health, or	Mental/Behavioral health inp	atient services	20%		\$600 per day up to 5 days	
substance abuse needs	Substance use disorder outpatient services		\$30		\$30	
	Substance use disorder inpa	tient services	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal care and preconcept	otion visits	No cost share		No cost share	
- Sg. Harroy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days	
	Home health care		20%		\$30	
	Outpatient Rehabilitation ser	vices	\$30		\$30	
Help	Outpatient Habilitation service	ces	\$30		\$30	
recovering or other special	Skilled nursing care		20%		\$300 per day up to 5 days	
health needs	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye	Eye exam 1 pair of glasses per year (or	contact lansac in lieu	No cost share		No cost share	
care	of glasses) Oral Exam	contact tenses in tieu	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered		Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar				Not Covered	
Child Dental	Gingivectomy per Quad	osed Root or			Not Covered	
Major	Extraction- Single Tooth Exp Erupted	USEU ROOT OF	Not Covered		Not Covered	
Services	Extraction- Complete Bony				Not Covered	
Child	Porcelain with Metal Crown				Not Covered	
Child	Medically necessary orthodo		Not Covered		Not Covered	

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Date: April 17, 2014

Summary of	Benefits and Coverag	je	Individ	ual	Individ	ual
Member Cost Share amounts describe the Enrollee's out of		Silve	r	Silver		
oocket costs.			Coinsurance Plan		Copay Plan	
Actuarial Value	e - AV Calculator		70.309	%	69.90%	6
	rall deductible		N/A		N/A	
Other individu	al deductibles for specific	services	* •••••	•		
	Medical Brand Drugo		\$2,00 \$250		\$2,000 \$250	
	Brand Drugs Dental		\$250		\$230	
ndividual Out-	-of-pocket maximum		\$6,25	0	\$6,25	0
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service T	уре	Share	Applies	Share	Applies
Health care provider's	Primary care visit or non-spo visit to treat an injury or illne		\$45		\$45	
office or						
linic visit	Specialist visit		\$65		\$65	
	Preventive care/ screening/	immunization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
lests	X-rays and Diagnostic Imag		\$65		\$65	
	Imaging (CT/PET scans, MF	२ls)	20%	Х	\$250	
Drugs to treat	Generic drugs		\$15		\$15	
liness or	Preferred brand drugs		\$50	X	\$50	X
condition	Non-preferred brand drugs		\$70	X	\$70	X
Nutnations	Specialty drugs Facility fee (e.g., ASC)		20% 20%	<u> </u>	20% 20%	X
Dutpatient	Physician/surgeon fees		20%		20%	
surgery	Emergency room services (v	waived if admitted)	\$250	x	\$250	X
	Emergency medical transpo		\$250	X	\$250	X
leed			φ200	~	φ£00	
mmediate attention	Urgent care		\$90		\$90	
lospital stay	Facility fee (e.g. hospital roc	vm)	20%	Х	20%	х
TOSPILAI SLAY	Physician/surgeon fee		20%		20%	
Mental health,	Mental/Behavioral health ou	tpatient services	\$45		\$45	
behavioral nealth, or	Mental/Behavioral health inp	patient services	20%	X	20%	Х
substance abuse needs	Substance use disorder out	patient services	\$45		\$45	
	Substance use disorder inpa	atient services	20%	х	20%	х
Pregnancy	Prenatal care and preconce		No cost share		No cost share	
	Delivery and all inpatient services	Hospital Professional	20% 20%	X	20%	х
	Home health care	1 IUICSSIUIIdi	20%		\$45	
	Outpatient Rehabilitation se	rvices	\$45		\$45	
lelp	Outpatient Habilitation servi		\$45		\$45	
ecovering or	Skilled nursing care		20%	х	20%	х
other special				^		^
nealth needs	Durable medical equipment		20%		20%	_
	Hospice service		No cost share		No cost share	
	Eye exam		No cost share		No cost share	_
Child eye	1 pair of glasses per year (o	r contact lenses in lieu				
care	of glasses)		No cost share		No cost share	
Child Device	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and	Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services						
	Root Canal- Molar				Not Covered	
	Gingivectomy per Quad Extraction- Single Tooth Exp				Not Covered	
Child Dental	Extraction- Single Tooth Evi	posed Root or	Not Covered		Not Covered	
Major	Erupted				Not Covered	
Child Dental Major Services					Not Covered Not Covered	
Vajor	Erupted Extraction- Complete Bony		Not Covered			

pocket costs. Actuarial Value Individual Over Other individua	hare amounts describe the E	nrollee's out of		ilver rance Plan			
Actuarial Value Individual Over Other individua			Combu		Silver Copay Plan 71.00%		
ndividual Over Dther individua			71	.50%			
Other individua	all doductible			N/A		I/A	
	al deductibles for specific	services				/A	
	Medical			1,500		,500	
	Brand Drugs Dental			\$500 \$0		500 \$0	
	of-pocket maximum		\$6	هو 6,250		,250	
Common			Member Cost		Member Cost		
Medical Event	Service T	/ре	Share	Deductible Applies	Share	Deductible Applie	
lealth care provider's	Primary care visit or non-spe visit to treat an injury or illne		\$45		\$45		
office or linic visit	Specialist visit		\$65		\$65		
	Preventive care/ screening/	immunization	No cost share		No cost share		
	-						
	Laboratory Tests X-rays and Diagnostic Imagi	na	\$45 \$65		\$45 \$65		
	Imaging (CT/PET scans, MF	-	20%	Х	\$250		
	Generic drugs		\$15		\$15		
Iness or	Preferred brand drugs		\$50	Х	\$50	Х	
ondition	Non-preferred brand drugs		\$70	Х	\$70	Х	
	Specialty drugs		20%	X	20%	X	
	Facility fee (e.g., ASC)		20%		20%	-	
	Physician/surgeon fees		20%		20%		
	Emergency room services (N Emergency medical transpo		\$250 \$250	X X	\$250 \$250	X	
leed	Emergency medical transpo	lalion	\$25U	A	\$250	^	
mmediate attention	Urgent care		\$90		\$90		
lochital stav	Facility fee (e.g. hospital roc	m)	20%	Х	20%	х	
iospital stay	Physician/surgeon fee		20%		20%	^	
lental health,	Mental/Behavioral health ou		\$45	Y	\$45	Y	
ealth, or	Mental/Behavioral health inp	atient services	20%	Х	20%	Х	
ubstance	Substance use disorder out	patient services	\$45		\$45		
	Substance use disorder inpa	atient services	20%	Х	20%	х	
	Prenatal care and preconce	otion visits	No cost share		No cost share		
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	0001	Y	
	services	Professional	20%		20%	Х	
	Home health care		20%		\$45		
	Outpatient Rehabilitation se		\$45		\$45		
•	Outpatient Habilitation servi	ces	\$45		\$45		
ecovering or	Skilled nursing care		20%	х	20%	х	
ther special ealth needs	Durable medical equipment		20%		20%		
	· · ·						
	Hospice service		No cost share		No cost share		
	Eye exam		No cost share		No cost share		
are	1 pair of glasses per year (o of glasses) Oral Exam	r contact lenses in lieu	No cost share		No cost share		
Child Dental Diagnostic Ind Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered		Not Covered		
hild Dental	Amalgam Fill - 1 Surface		Not Covered		Not Covered		
	Root Canal- Molar				Not Covered		
	Gingivectomy per Quad				Not Covered		
	Extraction- Single Tooth Exp	oosed Root or	Not Covered		Not Covered		
najor Services	Erupted		NOT COVERED				
	Extraction- Complete Bony				Not Covered	_	
	Porcelain with Metal Crown Medically necessary orthodo	ntice	Not Covered		Not Covered		

2015 Standard Benefit Plan Designs 9.5 EHB

Date: April 17, 2014

Summary of	Benefits and Coverage		SHO	Р
	hare amounts describe the Enr	rollee's out of	Silve	
pocket costs.			HSA P	
	e - AV Calculator		71.60	
	rall deductible	m/ieee	\$1,500 integrated	Med/Rx Ded
Jther Individua	al deductibles for specific se Medical	ervices	N/A	
	Brand Drugs		N/A	
	Dental		N/A \$6.25	
ndividual Out-	-of–pocket maximum		\$6,25	50
C				
Common Medical Event	Service Typ	e	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-speci visit to treat an injury or illness		20%	х
clinic visit	Specialist visit		20%	Х
	Preventive care/ screening/ im	nmunization	No cost share	
	Laboratory Tests		20%	X
Fests	X-rays and Diagnostic Imaging]	20%	X
	Imaging (CT/PET scans, MRIs		20%	X
Drugs to treat	Generic drugs		20%	Х
liness or	Preferred brand drugs		20%	X
condition	Non-preferred brand drugs		20%	X
Outpatient	Specialty drugs Facility fee (e.g., ASC)		20% 20%	<u> </u>
surgery	Physician/surgeon fees		20%	X
5 d. go. y	Emergency room services (wa	aived if admitted)	20%	X
	Emergency medical transporta	,	20%	X
Need Immediate attention	Urgent care		20%	x
	Facility fee (e.g. hospital room)	20%	X
lospital stay	Physician/surgeon fee	/	20%	X
Mental health,	Mental/Behavioral health outpa	atient services	20%	х
behavioral health, or	Mental/Behavioral health inpat	tient services	20%	Х
substance abuse needs	ubstance use disorder outpatient services		20%	x
	Substance use disorder inpatie	ent services	20%	Х
Pregnancy	Prenatal care and preconcepti	ion visits	No cost share	
Juney	Delivery and all inpatient	Hospital	20%	X
	services Home health care	Professional	20% 20%	<u> </u>
	Outpatient Rehabilitation servi	ices	20%	X
Help	Outpatient Habilitation service		20%	X
recovering or	Skilled nursing care		20%	х
other special	<u> </u>			
health needs	Durable medical equipment		20%	X
	Hospice service		No cost share	х
Child eye	Eye exam		No cost share	
care	1 pair of glasses per year (or c of glasses)	ontact lenses in lieu	No cost share	
	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and	Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo Erupted Extraction- Complete Bony Porcelain with Metal Crown	sed Root or	Not Covered	
Child	Medically necessary orthodont		Not Covered	

Summary of Benefits and Coverage

Actuarial Value		Member Cost Share amounts describe the Enrollee's out of pocket costs.		% FPL	150%-2009	
	e - AV Calculator		94.80	%	88.00	%
Individual Ove	erall deductible		\$0		N/A	
Other individu	al deductibles for specific se	ervices				
	Medical		\$0		\$500	
	Brand Drugs Dental		\$0 \$0		\$50 \$0	
Individual Out	-of-pocket maximum		\$2,25	0	\$2,25	0
			. ,		. ,	
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Typ	he	Share	Applies	Share	Applies
Health care provider's	Primary care visit or non-spective visit to treat an injury or illness		\$3		\$15	
office or					1	
clinic visit	Specialist visit		\$5		\$20	
	Preventive care/ screening/ ir	nmunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Fests	X-rays and Diagnostic Imagin	g	\$5		\$20	
	Imaging (CT/PET scans, MRI	s)	10%		15%	Х
Drugs to treat	Generic drugs		\$3		\$5	~ ~
liness or	Preferred brand drugs		\$5 \$10		\$15 \$25	X
condition	Non-preferred brand drugs Specialty drugs		\$10 10%		\$25 15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	
surgery	Physician/surgeon fees		10%		15%	
	Emergency room services (wa	aived if admitted)	\$25		\$75	Х
	Emergency medical transport		\$25		\$75	X
Need mmediate attention	Urgent care		\$6		\$30	
	Facility fee (e.g. hospital roon	n)	10%		15%	X
Hospital stay	Physician/surgeon fee	·/	10%		15%	~
Mental health.	Mental/Behavioral health outp	patient services	\$3		\$15	
behavioral nealth, or	Mental/Behavioral health inpa	atient services	10%		15%	х
substance abuse needs	Substance use disorder outpa	atient services	\$3		\$15	
	Substance use disorder inpat	ient services	10%		15%	х
Pregnancy	Prenatal care and preconcept		No cost share		No cost share	
	Delivery and all inpatient services	Hospital Professional	10%		15%	Х
	services Home health care	FIDIESSIONAL	10% 10%		15% 15%	
	Outpatient Rehabilitation serv	vices	10% \$3		\$15	_
Help	Outpatient Habilitation service		\$3		\$15	
recovering or						v
other special	Skilled nursing care		10%		15%	X
nealth needs	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Evo oxom		No cost charo		No cost share	
Child eye	Eye exam 1 pair of glasses per year (or o	contact lenses in lieu	No cost share		No cost share	
care	of glasses)		No cost share		No cost share	
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar					
Child Dontal	Gingivectomy per Quad					
Child Dental Major	Extraction- Single Tooth Expo	osed Root or	Not Covered		Not Covered	
	Erupted		NOT COVERED			
Services	Extraction- Complete Bony					
	Porcelain with Metal Crown					

Summary of Benefits and Coverage

	Benefits and Coverage Share amounts describe the Enrollee's out of	Silver Coinsur	ance Plan
pocket costs.		200%-250	% FPL
Actuarial Value	e - AV Calculator	rounded up t	o 74.0%
	rall deductible	N/A	
Other individu	al deductibles for specific services	.	•
	Medical	\$1,60	
	Brand Drugs Dental	\$250 \$0)
ndividual Out–of–pocket maximum		\$5,20	0
		. ,	
Common		Member Cost	_
Medical Event	Service Type	Share	Deductible Applies
	Service Type	onare	Applies
Health care provider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$40	
office or	Specialist visit	\$50	
clinic visit			
	Preventive care/ screening/ immunization	No cost share	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	20%	Х
Drugs to treat	Generic drugs	\$15	
illness or	Preferred brand drugs	\$35	X
condition	Non-preferred brand drugs	\$60	X
Outpotiont	Specialty drugs Facility fee (e.g., ASC)	20% 20%	X
Outpatient surgery	Physician/surgeon fees	20%	
sargery	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
Need immediate attention	Urgent care	\$80	
	Facility fee (e.g. hospital room)	20%	Х
Hospital stay	Physician/surgeon fee	20%	
Mental health,	Mental/Behavioral health outpatient services	\$40	
behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services Substance use disorder outpatient services	20% \$40	X
	Substance use disorder inpatient services	20%	x
	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital	20%	Х
	services Professional	20%	~
	Home health care	20%	
	Outpatient Rehabilitation services	\$40	
Help	Outpatient Habilitation services	\$40	
recovering or	Skilled nursing care	20%	х
other special health needs			
nealth needs	Durable medical equipment	20%	
	Hospice service	No cost share	
Ohill	Eye exam	No cost share	
Child eye	1 pair of glasses per year (or contact lenses in lieu		
care	of glasses)	No cost share	
	Oral Exam		
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		
and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Basic	Amalgam Fill - 1 Surface	Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface Root Canal- Molar	Not Covered	
Basic Services	Root Canal- Molar Gingivectomy per Quad	Not Covered	
Basic Services Child Dental	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or	Not Covered	
Basic Services Child Dental Major	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted		
Basic	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or		

Summary of Benefits and Coverage

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

 100%-150% FPL
 150%-200% FPL

pocket costs.	hare amounts describe the Er	nrollee's out of	Silver Cop 100%-150		Silver Cop 150%-200	
Actuarial Value	e - AV Calculator		94.90	%	88.00	1%
Individual Over	rall deductible		\$0		N/A	
	al deductibles for specific s	ervices	÷.			•
	Medical		\$0		\$50	
	Brand Drugs Dental		\$0 \$0		\$50 \$0	
	-of-pocket maximum		\$2,25	50	\$2,25	50
			+=,==	-	<i> </i>	
Common Medical Event	Service Ty	pe	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Hoalth caro	Primary care visit or non-spe visit to treat an injury or illnes		\$3		\$15	
clinic visit	Specialist visit		\$5		\$20	
	Preventive care/ screening/ in	nmunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
	X-rays and Diagnostic Imagin	-	\$5		\$20	
	Imaging (CT/PET scans, MR	IS)	\$50		\$100	
Drugs to treat	Generic drugs Preferred brand drugs		\$3 \$5		\$5 \$15	Х
illness or	Non-preferred brand drugs		هه \$10		\$15	X
condition	Specialty drugs		10%		15%	X
	Facility fee (e.g., ASC)		10%		15%	~
-	Physician/surgeon fees		10%		15%	
<u> </u>	Emergency room services (w	aived if admitted)	\$25		\$75	Х
			\$25 \$25		\$75 \$75	X
Need	Emergency medical transport	auUH	φ ∠ ວ		\$10	^
immediate attention	Urgent care		\$6		\$30	
Hospital stav	Facility fee (e.g. hospital roor Physician/surgeon fee	n)	10%		15%	х
Mental health,	Mental/Behavioral health outpatient services		\$3		\$15	
behavioral health, or	Mental/Behavioral health inpa	atient services	10%		15%	Х
substance abuse needs	Substance use disorder outp	atient services	\$3		\$15	
	Substance use disorder inpa	ient services	10%		15%	х
	Prenatal care and preconcep	tion visits	No cost share		No cost share	
	Delivery and all inpatient services	Hospital Professional	10%		15%	х
	Home health care	riorossional	\$3		\$15	
	Outpatient Rehabilitation service	vices	\$3		\$15	
Help	Outpatient Habilitation servic		\$3		\$15	
recovering or	•					
other special	Skilled nursing care		10%		15%	Х
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam		No cost share		No cost share	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu	No cost share		No cost share	
	of glasses) Oral Exam					
Diagnostic and	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered		Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad		Not Covered		Not Covered	
Major	Extraction- Single Tooth Exp	osed Root or	Not Covered		Not Covered	
Services	Erupted Extraction- Complete Bony		Not Covered		Not Covered	
	Porcelain with Metal Crown		Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodo	ntics	Not Covered		Not Covered	

Summary of Benefits and Coverage

•	Benefits and Coverage		Silver Con	
pocket costs.	hare amounts describe the Enrol	lee's out of	Silver Copa 200%-2509	
Actuarial Value	e - AV Calculator		73.50	%
Individual Ove	rall deductible		N/A	
Other individu	al deductibles for specific serv	ices		
	Medical		\$1,60	
	Brand Drugs Dental		\$250 \$0)
Individual Out	-of-pocket maximum		\$5,20	0
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-special visit to treat an injury or illness	ist practitioner	\$40	
clinic visit	inic visit Specialist visit Preventive care/ screening/ immunization			
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imaging		\$50	
	Imaging (CT/PET scans, MRIs)		\$250	
Drugs to treat	Generic drugs		\$15	
illness or	Preferred brand drugs		\$35	X
condition	Non-preferred brand drugs		\$60	X
Outpotierst	Specialty drugs Facility fee (e.g., ASC)		20%	X
Outpatient surgery	Physician/surgeon fees		20% 20%	
surgery	Emergency room services (waive	ed if admitted)	\$250	X
	Emergency medical transportation		\$250	X
Need immediate attention	Urgent care		\$80	~
Hospital stay	Facility fee (e.g. hospital room)	20%	x	
nospital stay	Physician/surgeon fee		2078	
Mental health,	Mental/Behavioral health outpatient services		\$40	
behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services		20% \$40	X
	Substance use disorder inpatien	t services	20%	x
	Prenatal care and preconception	i visits	No cost share	
Pregnancy	Delivery and all inpatient H	ospital	20%	х
		rofessional		
	Home health care	-	\$40	
Help	Outpatient Rehabilitation service Outpatient Habilitation services	S	\$40 \$40	
recovering or				
other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye	Eye exam		No cost share	
care	1 pair of glasses per year (or con of glasses)	tact lenses in lieu	No cost share	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray			
and	Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
	Root Canal- Molar		Not Covered	
Child Dental	Gingivectomy per Quad		Not Covered	
Major	Extraction- Single Tooth Expose	d Root or	Not Covered	
Services	Erupted Extraction- Complete Bony		Not Covered	
	Porcelain with Metal Crown		Not Covered	
Child Orthodontics	Medically necessary orthodontic	S	Not Covered	

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of Bronze Plan Bronze HSA Plan

Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator		Bronze Plan		Bronze HSA Plan	
		60.6	60%	59.40%	
Individual Over	rall deductible	\$5,000 integrate	ed Med/Rx Ded	\$4,500 integrat	ed Med/Rx
Other individua	al deductibles for specific services	,		,	
	Medical	N/		N/A	
	Brand Drugs	N/		N/A	
Individual Out-	Dental -of-pocket maximum	\$6,2		\$6,25	
inarriadai o'at		\$ 0,1		\$3,20	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$60	After 1st three non- preventive visits	40%	х
clinic visit	Specialist visit	\$70	Х	40%	Х
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	30%	X	40%	Х
	X-rays and Diagnostic Imaging	30%	X	40%	X
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
	Generic drugs	\$15	Х	40%	Х
Drugs to treat	Preferred brand drugs	\$50	Х	40%	Х
illness or	Non-preferred brand drugs	\$75	Х	40%	Х
condition	Specialty drugs	30%	X	40%	X
Outpatient	Facility fee (e.g., ASC)	30%	X	40%	X
surgery	Physician/surgeon fees	30%	X	40%	X
	Emergency room services (waived if admitted)	\$300	X	40%	X
	Emergency medical transportation	\$300	X	40%	X
Need immediate attention	Urgent care	\$120	After 1st three non- preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)	30%	X	40%	Х
nospital stay	Physician/surgeon fee	30%	X	40%	Χ
Mental health.	Mental/Behavioral health outpatient services	\$60	After 1st three non- preventive visits	40%	х
behavioral health, or	Mental/Behavioral health inpatient services	30%	x	40%	х
substance abuse needs	Substance use disorder outpatient services	\$60	After 1st three non- preventive visits	40%	х
	Substance use disorder inpatient services	30%	x	40%	х
_	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	30%	Х	40%	Х
	services Professional	30%	X	40%	X
	Home health care	30%	X	40%	X
	Outpatient Rehabilitation services	\$60	Х	40%	Х
Help	Outpatient Habilitation services	\$60	X	40%	X
recovering or					
other special	Skilled nursing care	30%	Х	40%	Х
health needs	Durable medical equipment	30%	Х	40%	Х
	Hospice service	No cost share	х	No cost share	х
01.11.1	Eye exam	No cost share		No cost share	
Child eye	1 pair of glasses per year (or contact lenses in lieu				
care	of glasses)	No cost share		No cost share	
	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Benefits and Coverage

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Member Cost Share amounts pocket costs.	s describe the Enrollee's out of	Catastrophic Plan
Actuarial Value - AV Calcul	ator	
Individual Overall deductib	le	\$6,600 integrated Med/Rx Ded
Other individual deductible	e for specific services	

Medical iso for appeal or on the set of the		rall deductible al deductibles for specific services	\$6,600 integrated	I Med/Rx Ded
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		Medically necessary orthodontics	Not Covered	

2015 Standard Benefit Plan Designs 9.5 EHB

Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the carrier pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of \$2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
- Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
- 5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 6) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month.
- 7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
- 8) For drugs to treat an illness or condition the copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.



2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits and Coverage		Standalone Dental Plan		Standalone Dental Plan	
Member Cost Share amou costs.	Member Cost Share amounts describe the Enrollee's out of pocket costs.		ntal EHB Plan	Pediatric Dental EHB Coinsurance Plan	
			ge 19	Up to Ag	je 19
Actuarial Value		83.09	%	86.89	6
Individual Deductible (wa	aived for Diagnostic & Preventive)	\$0		\$65 In Ne \$65 Out of	
Family Deductible (Two ((waived for Diagnostic &	Preventive)	\$0		\$130 In Ne \$130 Out of	Network
Individual Out of Pocket		\$350		\$35	
	ximum (Two or More Children)	\$700 \$0	0	\$70 \$0)
Office Copay Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)		None		None	
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	Non	e	Non	e
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Oral Exam	\$0		0%	
	Preventive - Cleaning	\$0		0%	
Diagnostic & Preventive	Preventive - X-ray	\$0		0%	
	Sealants per Tooth	\$0		0%	
	Topical Fluoride Application	\$0		0%	
	Space Maintainers - Fixed	\$0		0%	
Basic Services	Amalgam Fill - One Surface	\$25		20%	х
	Root Canal - Molar	\$300			
Major Services - Crowns	Gingivectomy per Quad	\$150			
and Casts, Endodontics, Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		50%	х
Prosthodontics, Oral	Extraction - Complete Bony	\$160			
Surgery	Crown - Porcelain with Metal	\$300			
Orthodontia	Medically Necessary Orthodontia	\$350		50%	х

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.

2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.

4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)5) Each adult is responsible for an individual deductible.6) Families eligible to purchase a Family Dental Plan must include

at least one adult who has purchased a Qualified Health Plan through the Exchange.

7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.

8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits	and Coverage	Family Dental Plan			
Member Cost Share amou costs.	nts describe the Enrollee's out of pocket	Pediatric Dental EHB Copay Plan		Adult De Copay I	
		Up to Age 19		Age 19 and Older	
Actuarial Value		83.	0%	Not Calculated	
Individual Deductible (wa	aived for Diagnostic & Preventive)	\$	0	\$0	
Family Deductible (Two of (waived for Diagnostic &	Preventive)	\$	0	\$0	
Individual Out of Pocket			50	Not Appli	
	ximum (Two or More Children)	· · · · ·	00	Not Appli	cable
Office Copay		\$	0	\$0	
Waiting Period (Waivered Condition provision, as 1357.50 (a)(3)(J)(4) and Insurand		None		None	
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None		None	
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
Diagnostic & Preventive	Preventive - X-ray	\$0		\$0	
Diagnostic & Freventive	Sealants per Tooth	\$0		Not Covered	
	Topical Fluoride Application	\$0		Not Covered	
	Space Maintainers - Fixed	\$0		Not Covered	
Basic Services	Amalgam Fill - One Surface	\$25		\$25	
	Root Canal - Molar	\$300		\$300	
Major Services - Crowns	Gingivectomy per Quad	\$150		\$150	
and Casts, Endodontics, Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65	
Prosthodontics, Oral	Extraction - Complete Bony	\$160		\$160	
Surgery	Crown - Porcelain with Metal	\$300		\$300	
Orthodontia	Medically Necessary Orthodontia	\$350		Not Covered	

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.

2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.

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2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits	and Coverage		Family De	ental Plan	
·	nts describe the Enrollee's out of pocket	Pediatric Dental EHB Coinsurance Plan		Adult De Coinsuranc	
		Up to Age 19		Age 19 and Older	
Actuarial Value		86.8%		Not Calculated	
Individual Deductible (wa	nived for Diagnostic & Preventive)	\$65 In Net \$65 Out of N		\$50 In Network/ \$50 Out of Network	
Family Deductible (Two of (waived for Diagnostic &	Preventive)	\$130 In Network/ \$130 Out of Network		Not Applicable	
Individual Out of Pocket		\$350		Not Appli	
	kimum (Two or More Children)	\$700 \$0		Not Applicable \$0	
Office Copay Waiting Period (Waivered Condition provision, as 1357.50 (a)(3)(J)(4) and Insurance		None		6 months for Major Services, Waived with Proof of Prior Coverage	
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None		\$1,500	
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Oral Exam	0%		0%	
	Preventive - Cleaning	0%		0%	
Diagnostic & Preventive	Preventive - X-ray	0%		0%	
	Sealants per Tooth	0%		Not Covered	
	Topical Fluoride Application	0%		Not Covered	
Paris Ormitan	Space Maintainers - Fixed	0%		Not Covered	
Basic Services	Amalgam Fill - One Surface Root Canal - Molar	20%	<u> </u>	20%	<u> </u>
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction - Complete Bony Crown - Porcelain with Metal	50%	x	50%	x
Orthodontia	Medically Necessary Orthodontia	50%	Х	Not Covered	

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.

2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
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STATE OF CALIFORNIA -- DEPARTMENT OF FINANCE ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT

	Economic Init /	ICI SIAI		
department NAME California Health Benefit Exchange	contact person Brandon Ross		email address brandon.ross@covered.c	TELEPHONE NUMBER 916-228-8281
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400 2015 Standard Benefit Design Rulemak	king			NOTICE FILE NUMBER
A. ESTIMATED PRIVATE SECTOR COST IMPA	CTS Include calculations and	assumptions in	the rulemaking record.	
	e. Imposes rep f. Imposes pres g. Impacts indi h. None of the	criptive Instead viduals above (Explain mplete this Ed	of performance below): conomic Impact Statement.	
2. The(Agency/Department)	estimates that the ec	onomic impact	of this regulation (which includes t	ne fiscal impact) is:
 Below \$10 million Between \$10 and \$25 million Between \$25 and \$50 million Over \$50 million [If the economic impact is service] 	s over \$50 million, agencies are 1 nt Code Section 11346.3(c)]	equired to subm	it a <u>Standardized Regulatory Impact /</u>	Assessment
3. Enter the total number of businesses impacted:				
Describe the types of businesses (Include nonp	rofits):			
Enter the number or percentage of total businesses impacted that are small businesses:				
4. Enter the number of businesses that will be crea	ated:	eliminated:		
Explain:				
5. Indicate the geographic extent of impacts:] Statewide] Local or regional (List areas):			
6. Enter the number of jobs created:	and eliminated:			
Describe the types of jobs or occupations impa	cted:			
 Will the regulation affect the ability of California other states by making it more costly to produce If YES, explain briefly: 		YES	ΝΟ	
				PAGE 1

STATE OF CALIFORNIA -- DEPARTMENT OF FINANCE ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT (CONTINUED)

B. ESTIMATED COSTS Include calculations and ass	sumptions in the r	ulemaking record.		
1. What are the total statewide dollar costs that busin	esses and individu	als may incur to comply with this	regulation over it:	s lifetime? \$
a. Initial costs for a small business: \$				
b. Initial costs for a typical business: \$				
		Annual ongoing costs: \$		
d. Describe other economic costs that may occur:				
· · · · · · · · · · · · · · · · · · ·				
2. If multiple industries are imported enter the share	of total costs for	ach industry		
2. If multiple industries are impacted, enter the share				
 If the regulation imposes reporting requirements, e Include the dollar costs to do programming, record keep 	nter the annual co	osts a typical business may incur to nd other paperwork, whether or not	o comply with the t the paperwork mi	se requirements. Ist be submitted. \$
4. Will this regulation directly impact housing costs?	YES	NO		
		annual dollar cost per housing uni	t: \$	
		Number of unit	ts:	<
5. Are there comparable Federal regulations?	YES	NO		
Explain the need for State regulation given the exist	tence or absence of	of Federal regulations:		
Enter any additional costs to businesses and/or indi	viduals that may t	pe due to State - Federal difference	es: \$	
C. ESTIMATED BENEFITS Estimation of the dollar v	alue of benefits is	not specifically required by rulem	aking law, but en	couraged.
 Briefly summarize the benefits of the regulation, whealth and welfare of California residents, worker statements 	nich may include a afety and the Stat	among others, the e's environment:		
		·····		
2. Are the benefits the result of: Specific statutory	/ requirements, or	goals developed by the age	ency based on bro	ad statutory authority?
Explain:				
3. What are the total statewide benefits from this regu	ulation over its life	time? \$		
				m this regulation.
4. Briefly describe any expansion of businesses curren	itly doing busines	s within the State of California tha	it would result from	
	·····	- Mary		······
D. ALTERNATIVES TO THE REGULATION Include specifically required by rulemaking law, but encou	,	assumptions in the rulemaking re		
1. List alternatives considered and describe them belo				

STATE OF CALIFORNIA --- DEPARTMENT OF FINANCE ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT (CONTINUED)

2. Summarize the tot	al statewide costs and benef	its from this regulation and each alternative consider	ed:
Regulation:	Benefit: \$	Cost: \$	
Alternative 1:	Benefit: \$	Cost: \$	
		Cost: \$	
	quantification issues that are		
of estimated cost	s and benefits for this regul	ation or alternatives:	
regulation manda	tes the use of specific techr	r performance standards as an alternative, if a nologies or equipment, or prescribes specific ndards considered to lower compliance costs?	
Explain:			
			·
E. MAJOR REGULA	TIONS Include calculations	s and assumptions in the rulemaking record.	
(al Protection Agency (Cal/EPA) boards, office ving (per Health and Safety Code section 5700	
1. Will the estimated	costs of this regulation to Ca	alifornia business enterprises exceed \$10 million ?	YES NO
		If YES, complete E2. and E3 If NO, skip to E4	
2. Briefly describe ead	ch alternative, or combinatio	on of alternatives, for which a cost-effectiveness analy	sis was performed:
Alternative 1:			
Alternative 2:			
(Attach additional p	pages for other alternatives)		
3 For the regulation	and each alternative just de	escribed, enter the estimated total cost and overall co	st-effectiveness ratio:
	al Cost \$		
		Cost-effectiveness ratio: \$	
	al Cost \$		
4. Will the regulation exceeding \$50 mil	subject to OAL review have a	an estimated economic impact to business enterprise between the date the major regulation is estimated t	s and individuals located in or doing business in California to be filed with the Secretary of State through12 months
	NO		
		<u>dized Regulatory Impact Assessment (SRIA)</u> as specified ude the SRIA in the Initial Statement of Reasons.	in
5. Briefly describe the	e following:		
The increase or de	crease of investment in the S	State:	
The incentive for i	nnovation in products, mate	rials or processes:	
		not limited to, benefits to the health, safety, and welf nment and quality of life, among any other benefits i	

STATE OF CALIFORNIA -- DEPARTMENT OF FINANCE ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD.	399	(REV.	12/2013)	

FISCAL IMPACT STATEMENT

	FFECT ON LOCAL GOVERNMEN ar and two subsequent Fiscal Year		s 1 through 6 and attach calculatio	ons and assumptions of fiscal impact for the	
			nbursable by the State. (Approxima d Sections 17500 et seq. of the Gov		
\$					
🗌 a. F	unding provided in				
	Budget Act of	or Chapter	, Statutes of		
🗌 b. F	unding will be requested in the Go	vernor's Budget Act of 			
		Fiscal Year:			
2. Additi (Pursu	onal expenditures in the current S ant to Section 6 of Article XIII B of 1	tate Fiscal Year which are NOT he California Constitution and	reimbursable by the State. (Appro d Sections 17500 et seq. of the Gov	ximate) ernment Code).	
\$					
	ason(s) this regulation is not reimbu		iate information:		
a. In	plements the Federal mandate co	ontained in			_
🔲 b. Ir	nplements the court mandate set			Court.	
	Case of:		Vs		
🗌 c. In	plements a mandate of the peopl	e of this State expressed in th	eir approval of Proposition No.		
	Date of Election:				
🗌 d. Is	sued only in response to a specific	request from affected local e	ntity(s).		
	Local entity(s) affected:	-			
e. W	ill be fully financed from the fees,	revenue, etc. from:		^	
	Authorized by Section:		_ of the	Code;	
🗌 f. Pi	ovides for savings to each affected	l unit of local government wh	ich will, at a minimum, offset any a	dditional costs to each;	
🗌 g. C	reates, eliminates, or changes the p	penalty for a new crime or infr	action contained in		
🔲 3. Annua	l Savings. (approximate)				
\$					
4. No add	litional costs or savings. This regula	ion makes only technical, non-	substantive or clarifying changes to	current law regulations.	
🗙 5. No fisc	al impact exists. This regulation do	es not affect any local entity or	program.		
🔲 6. Other.	Explain	· · · · · · · · · · · · · · · · · · ·			

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STATE OF CALIFORNIA -- DEPARTMENT OF FINANCE ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

FISCAL IMPACT STATEMENT (CONTINUED)

B. FISCAL EFFECT ON STATE GOVERNMENT Indicate appropriate boxes 1 through 4 and attach calcula year and two subsequent Fiscal Years.	tions and assumptions of fiscal impact for the current
1. Additional expenditures in the current State Fiscal Year. (Approximate)	
\$	
It is anticipated that State agencies will:	
a. Absorb these additional costs within their existing budgets and resources.	
b. Increase the currently authorized budget level for the Fiscal Year	
2. Savings in the current State Fiscal Year. (Approximate)	
\$	
X 3. No fiscal impact exists. This regulation does not affect any State agency or program.	
4. Other. Explain	
C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS Indicate appropriate boxes 1 throug impact for the current year and two subsequent Fiscal Years.	h 4 and attach calculations and assumptions of fiscal
1. Additional expenditures in the current State Fiscal Year. (Approximate)	
\$	
2. Savings in the current State Fiscal Year. (Approximate)	
\$	
3. No fiscal impact exists. This regulation does not affect any federally funded State agency or program.	
X 4. Other. Explain Estimated cost impact to the Federal Funds (Grant) is \$332,000 in f	iscal year 2013-14.
This proposal has no impact on the General Fund. Please see the attach	ment for additional detail.
FISCAL OFFICER SIGNATURE	DATE
2 mm	4-1-14
The signature attests that the agency has completed the STD. 399 according to the instructions in	
the impacts of the proposed rulemaking. State boards, offices, or departments not under an Agen highest ranking official in the organization.	cy secretary must have the form signed by the
AGENCY SECRETARY	DATE
a '// h	4/4/14
Finance approval and signature is required when SAM sections 6601-6616 require completion of	Fiscal Impact Statement in the STD. 399.
DEPARTMENT OF FINANCE PROGRAM BUDGET MANAGER	DATE
2	

2015 Standard Benefit Design Rulemaking Std 399

Personal Services (PS) & Operating Expenses & Equipment (OE&E) Costs

				Cos	t (per	Cost (per classification)	(u						
Classification	Salan	alary Cost ^{1/}	ä	Benefits ^{2/}	F	Total PS	Carolin	OE&E ^{3/}	PS	PS + OE&E	Staffing Level ⁴	H	Total Cost
C.E.A Level B @ 10%	φ	3,286	φ	1,282	\$	4,568	ŝ	467	\$	5,035	1.0	G	5,035
Staff Services Manager I (SSM I) @ 30%	θ	6,834	ŝ	2,665	\$	9,499	θ	1,400	-	10,899	2.0	θ	21,798
Staff Services Manager II (SSM II) @ 20%	ŝ	5,002	θ	1,951	\$	6,953	69	933	-	7,886	1.0	69	7,886
Research Program Specialist II (RPS II) @ 40%	÷	9,563	θ	3,730	•	13,293	\$	1,867	-	15,160	1.0	÷	15,160
Assoc. Gov. Program Analyst (AGPA) @ 50%	ŝ	9,908	¢	3,864	\$	13,772	θ	2,333	\$	16,105	3.0	69	48,316
Total	\$	34,593	φ	13,492	\$	48,085	ω	7,000	\$	55,085	8.0	\$	98,195

Salary calculations based off of mid-step of classification and prorated based on the amount of time dedicated to the development of the recertification and new entrant application.
 Benefits calculated via standard benefit rate (39%).
 OE&E includes annual standard complement at \$14,000, prorated based on the same parameters as salary.
 Staffing level and associated classifications provided by program.
 (4) month measurement period is 02/01/14 - 05/31/2014.

Contract Costs

Contract/Contractor		Amount
Bluecrane, Inc.	θ	57,800
Bertko Acturial Associates, LLC	\$	13,600
Milliman, Inc.	¢	108,800
Tori Group	69	53,720
	Total \$	233,920

Total Summary

Amount	98,195	233,920	332,115
	ю	Ş	Total Cost \$
Cost Category	Total PS & OE&E	Total Contracts	