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: http://hbex.coveredca.com/regulations/.

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

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 re-adoption. 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, 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

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

2015 Standard Benefit Plan Designs
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COVERED CALIFORNIA™

Summary of Benefits and Coverage

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

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$4,000	$4,000

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$20		$20	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Generic drugs		$5		$5	
	Preferred brand drugs		$15		$15	
	Non-preferred brand drugs		$25		$25	
	Specialty drugs		10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%			
Need immediate attention	Emergency room services (waived if admitted)		$150		$150	
	Emergency medical transportation		$150		$150	
	Urgent care		$40		$40	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$20		$20	
	Mental/Behavioral health inpatient services		10%		$250 per day up to 5 days	
	Substance use disorder outpatient services		$20		$20	
	Substance use disorder inpatient services		10%		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%			
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$20		$20	
	Outpatient Habilitation services		$20		$20	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		No cost share		No cost share	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		$25	
Child Dental Major Services	Root Canal- Molar		50%		$300	
	Gingivectomy per Quad				$150	
	Extraction- Single Tooth Exposed Root or Erupted				$65	
	Extraction- Complete Bony				$160	
	Porcelain with Metal Crown				$300	
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage

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

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$30		$30	
	Specialist visit		$50		$50	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$30		$30	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50		$50	
	Non-preferred brand drugs		$70		$70	
	Specialty drugs		20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%			
Need immediate attention	Emergency room services (waived if admitted)		$250		$250	
	Emergency medical transportation		$250		$250	
	Urgent care		$60		$60	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$30		$30	
	Mental/Behavioral health inpatient services		20%		$600 per day up to 5 days	
	Substance use disorder outpatient services		$30		$30	
	Substance use disorder inpatient services		20%		$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$30	
	Outpatient Rehabilitation services		$30		$30	
	Outpatient Habilitation services		$30		$30	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		No cost share		No cost share	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		$25	
Child Dental Major Services	Root Canal- Molar		50%		$300	
	Gingivectomy per Quad				$150	
	Extraction- Single Tooth Exposed Root or Erupted				$65	
	Extraction- Complete Bony				$160	
	Porcelain with Metal Crown				$300	
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	Individual Silver Coinsurance Plan	Individual Silver Copay Plan
Actuarial Value - AV Calculator	70.30%	69.90%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	$2,000	$2,000
Brand Drugs	$250	$250
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$45		$45	
	Specialist visit		$65		$65	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$45		$45	
	X-rays and Diagnostic Imaging		$65		$65	
	Imaging (CT/PET scans, MRIs)		20%	X	$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50	X	$50	X
	Non-preferred brand drugs		$70	X	$70	X
	Specialty drugs		20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X	$250	X
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$90		$90	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$45		$45	
	Mental/Behavioral health inpatient services		20%	X	20%	X
	Substance use disorder outpatient services		$45		$45	
	Substance use disorder inpatient services		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		No cost share		No cost share	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		$25	
Child Dental Major Services	Root Canal- Molar		50%		$300	
	Gingivectomy per Quad				$150	
	Extraction- Single Tooth Exposed Root or Erupted				$65	
	Extraction- Complete Bony				$160	
	Porcelain with Metal Crown				$300	
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage

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

	SHOP Silver Coinsurance Plan	SHOP Silver Copay Plan
Actuarial Value - AV Calculator	71.50%	71.00%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	$1,500	$1,500
Brand Drugs	$500	$500
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$45		$45	
	Specialist visit		$65		$65	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$45		$45	
	X-rays and Diagnostic Imaging		$65		$65	
	Imaging (CT/PET scans, MRIs)		20%	X	$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50	X	$50	X
	Non-preferred brand drugs		$70	X	$70	X
	Specialty drugs		20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X	$250	X
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$90		$90	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$45		$45	
	Mental/Behavioral health inpatient services		20%	X	20%	X
	Substance use disorder outpatient services		$45		$45	
	Substance use disorder inpatient services		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		No cost share		No cost share	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		$25	
Child Dental Major Services	Root Canal- Molar		50%		$300	
	Gingivectomy per Quad				$150	
	Extraction- Single Tooth Exposed Root or Erupted				$65	
	Extraction- Complete Bony				$160	
	Porcelain with Metal Crown				$300	
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	SHOP Silver HSA Plan
Actuarial Value - AV Calculator	71.60%
Individual Overall deductible	$1,500 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		20%	X
	Preferred brand drugs		20%	X
	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
Need immediate attention	Emergency room services (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	X
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		20%	X
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
Child Dental Major Services	Root Canal- Molar		50%	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.80%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat illness or condition	Generic drugs		$3		$5	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%		15%	X
	Physician/surgeon fee		10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional	10%		15%	
Help recovering or other special health needs	Home health care		10%		15%	
	Outpatient Rehabilitation services		$3		$15	
	Outpatient Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		No cost share		No cost share	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
Child Dental Major Services	Root Canal- Molar		50%		50%	
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or Erupted					
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodontics		50%		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 200%-250% FPL
Actuarial Value - AV Calculator	rounded up to 74.0%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$35	X
	Non-preferred brand drugs		$60	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care		20%	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
Child Dental Major Services	Root Canal- Molar		50%	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.90%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$3		$15	
	Specialist visit	$5		$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$3		$15	
	X-rays and Diagnostic Imaging	$5		$20	
	Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition	Generic drugs	$3		$5	
	Preferred brand drugs	$5		$15	X
	Non-preferred brand drugs	$10		$25	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	
	Physician/surgeon fees	10%		15%	
Need immediate attention	Emergency room services (waived if admitted)	$25		$75	X
	Emergency medical transportation	$25		$75	X
	Urgent care	$6		$30	
Hospital stay	Facility fee (e.g. hospital room)	10%		15%	X
	Physician/surgeon fee				
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$3		$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	$3		$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	10%		15%	X
	Delivery and all inpatient services — Professional				
Help recovering or other special health needs	Home health care	$3		$15	
	Outpatient Rehabilitation services	$3		$15	
	Outpatient Habilitation services	$3		$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	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	No cost share		No cost share	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25		$25	
Child Dental Major Services	Root Canal- Molar	$300		$300	
	Gingivectomy per Quad	$150		$150	
	Extraction- Single Tooth Exposed Root or Erupted	$65		$65	
	Extraction- Complete Bony	$160		$160	
	Porcelain with Metal Crown	$300		$300	
Child Orthodontics	Medically necessary orthodontics	$1,000		$1,000	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.50%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$35	X
	Non-preferred brand drugs		$60	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional		
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		$25	
Child Dental Major Services	Root Canal- Molar		$300	
	Gingivectomy per Quad		$150	
	Extraction- Single Tooth Exposed Root or Erupted		$65	
	Extraction- Complete Bony		$160	
	Porcelain with Metal Crown		$300	
Child Orthodontics	Medically necessary orthodontics		$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	60.60%	59.40%
Individual Overall deductible	$5,000 integrated Med/Rx Ded	$4,500 integrated Med/Rx
Other individual deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	$0	N/A
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$60	After 1st three non-preventive visits	40%	X
	Specialist visit		$70	X	40%	X
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		30%	X	40%	X
	X-rays and Diagnostic Imaging		30%	X	40%	X
	Imaging (CT/PET scans, MRIs)		30%	X	40%	X
Drugs to treat illness or condition	Generic drugs		$15	X	40%	X
	Preferred brand drugs		$50	X	40%	X
	Non-preferred brand drugs		$75	X	40%	X
	Specialty drugs		30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)		30%	X	40%	X
	Physician/surgeon fees		30%	X	40%	X
Need immediate attention	Emergency room services (waived if admitted)		$300	X	40%	X
	Emergency medical transportation		$300	X	40%	X
	Urgent care		$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		30%	X	40%	X
	Physician/surgeon fee		30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$60	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient services		30%	X	40%	X
	Substance use disorder outpatient services		$60	After 1st three non-preventive visits	40%	X
	Substance use disorder inpatient services		30%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	30%	X	40%	X
		Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care		30%	X	40%	X
	Outpatient Rehabilitation services		$60	X	40%	X
	Outpatient Habilitation services		$60	X	40%	X
	Skilled nursing care		30%	X	40%	X
	Durable medical equipment		30%	X	40%	X
	Hospice service		No cost share	X	No cost share	X
Child eye care	Eye exam		No cost share		No cost share	
	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		No cost share		No cost share	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
Child Dental Major Services	Root Canal- Molar		50%		50%	
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or Erupted					
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodontics		50%		50%	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Individual Overall deductible	$6,600 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Generic drugs		0%	X
	Preferred brand drugs		0%	X
	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
Need immediate attention	Emergency room services (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	After 1st three non-preventive visits
	Substance use disorder inpatient services		0%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	x
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	X
Child Dental Major Services	Root Canal- Molar		50%	X
	Gingivectomy per Quad			X
	Extraction- Single Tooth Exposed Root or Erupted			X
	Extraction- Complete Bony			X
	Porcelain with Metal Crown			X
Child Orthodontics	Medically necessary orthodontics		50%	X

See endnotes.

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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.
4) 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.

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Summary of Benefits and Coverage

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

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$4,000	$4,000

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$20		$20	
	Specialist visit	$40		$40	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$20		$20	
	X-rays and Diagnostic Imaging	$40		$40	
	Imaging (CT/PET scans, MRIs)	10%		$150	
Drugs to treat illness or condition	Generic drugs	$5		$5	
	Preferred brand drugs	$15		$15	
	Non-preferred brand drugs	$25		$25	
	Specialty drugs	10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)	10%		$250	
	Physician/surgeon fees	10%			
Need immediate attention	Emergency room services (waived if admitted)	$150		$150	
	Emergency medical transportation	$150		$150	
	Urgent care	$40		$40	
Hospital stay	Facility fee (e.g. hospital room)	10%		$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20		$20	
	Mental/Behavioral health inpatient services	10%		$250 per day up to 5 days	
	Substance use disorder outpatient services	$20		$20	
	Substance use disorder inpatient services	10%		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	10%		$250 per day up to 5 days	
	Delivery and all inpatient services — Professional	10%			
Help recovering or other special health needs	Home health care	10%		$20	
	Outpatient Rehabilitation services	$20		$20	
	Outpatient Habilitation services	$20		$20	
	Skilled nursing care	10%		$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	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	Not Covered		Not Covered	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar	Not Covered		Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted			Not Covered	
	Extraction- Complete Bony			Not Covered	
	Porcelain with Metal Crown			Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$30		$30	
	Specialist visit		$50		$50	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$30		$30	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50		$50	
	Non-preferred brand drugs		$70		$70	
	Specialty drugs		20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%			
Need immediate attention	Emergency room services (waived if admitted)		$250		$250	
	Emergency medical transportation		$250		$250	
	Urgent care		$60		$60	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$30		$30	
	Mental/Behavioral health inpatient services		20%		$600 per day up to 5 days	
	Substance use disorder outpatient services		$30		$30	
	Substance use disorder inpatient services		20%		$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$30	
	Outpatient Rehabilitation services		$30		$30	
	Outpatient Habilitation services		$30		$30	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad				Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted				Not Covered	
	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

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

	Individual Silver Coinsurance Plan	Individual Silver Copay Plan
Actuarial Value - AV Calculator	70.30%	69.90%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	$2,000	$2,000
Brand Drugs	$250	$250
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$45		$45	
	Specialist visit		$65		$65	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$45		$45	
	X-rays and Diagnostic Imaging		$65		$65	
	Imaging (CT/PET scans, MRIs)		20%	X	$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50	X	$50	X
	Non-preferred brand drugs		$70	X	$70	X
	Specialty drugs		20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X	$250	X
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$90		$90	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$45		$45	
	Mental/Behavioral health inpatient services		20%	X	20%	X
	Substance use disorder outpatient services		$45		$45	
	Substance use disorder inpatient services		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad				Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted				Not Covered	
	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	SHOP Silver Coinsurance Plan	SHOP Silver Copay Plan
Actuarial Value - AV Calculator	71.50%	71.00%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	$1,500	$1,500
Brand Drugs	$500	$500
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$45		$45	
	Specialist visit	$65		$65	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$45		$45	
	X-rays and Diagnostic Imaging	$65		$65	
	Imaging (CT/PET scans, MRIs)	20%	X	$250	
Drugs to treat illness or condition	Generic drugs	$15		$15	
	Preferred brand drugs	$50	X	$50	X
	Non-preferred brand drugs	$70	X	$70	X
	Specialty drugs	20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X	$250	X
	Emergency medical transportation	$250	X	$250	X
	Urgent care	$90		$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45		$45	
	Mental/Behavioral health inpatient services	20%	X	20%	X
	Substance use disorder outpatient services	$45		$45	
	Substance use disorder inpatient services	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	20%	X	20%	X
	Delivery and all inpatient services — Professional	20%			
Help recovering or other special health needs	Home health care	20%		$45	
	Outpatient Rehabilitation services	$45		$45	
	Outpatient Habilitation services	$45		$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	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	Not Covered		Not Covered	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar	Not Covered		Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted			Not Covered	
	Extraction- Complete Bony			Not Covered	
	Porcelain with Metal Crown			Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	**SHOP** **Silver HSA Plan**
Actuarial Value - AV Calculator	71.60%
Individual Overall deductible	$1,500 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		20%	X
	Preferred brand drugs		20%	X
	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
Need immediate attention	Emergency room services (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	X
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		20%	X
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.80%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat illness or condition	Generic drugs		$3		$5	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%		15%	X
	Physician/surgeon fee		10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional	10%		15%	
Help recovering or other special health needs	Home health care		10%		15%	
	Outpatient Rehabilitation services		$3		$15	
	Outpatient Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	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		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or Erupted					
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 200%-250% FPL
Actuarial Value - AV Calculator	rounded up to 74.0%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$35	X
	Non-preferred brand drugs		$60	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care		20%	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.90%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	$3		$15	
	Specialist visit	$5		$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	$3		$15	
	X-rays and Diagnostic Imaging	$5		$20	
	Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition	Generic drugs	$3		$5	
	Preferred brand drugs	$5		$15	X
	Non-preferred brand drugs	$10		$25	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	
	Physician/surgeon fees	10%		15%	
Need immediate attention	Emergency room services (waived if admitted)	$25		$75	X
	Emergency medical transportation	$25		$75	X
	Urgent care	$6		$30	
Hospital stay	Facility fee (e.g. hospital room)	10%		15%	X
	Physician/surgeon fee				
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$3		$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	$3		$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services — Hospital	10%		15%	X
	Delivery and all inpatient services — Professional				
Help recovering or other special health needs	Home health care	$3		$15	
	Outpatient Rehabilitation services	$3		$15	
	Outpatient Habilitation services	$3		$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
Child eye care	Eye exam	No cost share		No cost share	
	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	Not Covered		Not Covered	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar	Not Covered		Not Covered	
	Gingivectomy per Quad	Not Covered		Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony	Not Covered		Not Covered	
	Porcelain with Metal Crown	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.50%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$35	X
	Non-preferred brand drugs		$60	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional		
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered	
	Gingivectomy per Quad		Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted		Not Covered	
	Extraction- Complete Bony		Not Covered	
	Porcelain with Metal Crown		Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	60.60%	59.40%
Individual Overall deductible	$5,000 integrated Med/Rx Ded	$4,500 integrated Med/Rx
Other individual deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	$0	N/A
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$60	After 1st three non-preventive visits	40%	X
	Specialist visit		$70	X	40%	X
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		30%	X	40%	X
	X-rays and Diagnostic Imaging		30%	X	40%	X
	Imaging (CT/PET scans, MRIs)		30%	X	40%	X
Drugs to treat illness or condition	Generic drugs		$15	X	40%	X
	Preferred brand drugs		$50	X	40%	X
	Non-preferred brand drugs		$75	X	40%	X
	Specialty drugs		30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)		30%	X	40%	X
	Physician/surgeon fees		30%	X	40%	X
Need immediate attention	Emergency room services (waived if admitted)		$300	X	40%	X
	Emergency medical transportation		$300	X	40%	X
	Urgent care		$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		30%	X	40%	X
	Physician/surgeon fee		30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$60	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient services		30%	X	40%	X
	Substance use disorder outpatient services		$60	After 1st three non-preventive visits	40%	X
	Substance use disorder inpatient services		30%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	30%	X	40%	X
		Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care		30%	X	40%	X
	Outpatient Rehabilitation services		$60	X	40%	X
	Outpatient Habilitation services		$60	X	40%	X
	Skilled nursing care		30%	X	40%	X
	Durable medical equipment		30%	X	40%	X
	Hospice service		No cost share	X	No cost share	X
Child eye care	Eye exam		No cost share		No cost share	
	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		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or Erupted					
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Individual Overall deductible	$6,600 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Generic drugs		0%	X
	Preferred brand drugs		0%	X
	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
Need immediate attention	Emergency room services (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	After 1st three non-preventive visits
	Substance use disorder inpatient services		0%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	x
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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.
4) 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.

COVERED CALIFORNIA™

2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits and Coverage

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

	Standalone Dental Plan Pediatric Dental EHB Copay Plan	Standalone Dental Plan Pediatric Dental EHB Coinsurance Plan
	Up to Age 19	Up to Age 19
Actuarial Value	83.0%	86.8%
Individual Deductible (waived for Diagnostic & Preventive)	$0	$65 In Network/ $65 Out of Network
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)	$0	$130 In Network/ $130 Out of Network
Individual Out of Pocket Maximum	$350	$350
Family Out of Pocket Maximum (Two or More Children)	$700	$700
Office Copay	$0	$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)	None	None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)	None	None

Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Diagnostic & Preventive	Oral Exam	$0		0%	
	Preventive - Cleaning	$0		0%	
	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%	x
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	$300		50%	x
	Gingivectomy per Quad	$150			
	Extraction- Single Tooth Exposed Root or Erupted	$65			
	Extraction - Complete Bony	$160			
	Crown - Porcelain with Metal	$300			
Orthodontia	Medically Necessary Orthodontia	$350		50%	x

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 in-network 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.

COVERED CALIFORNIA™

2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits and Coverage

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

	Family Dental Plan	
	Pediatric Dental EHB Copay Plan	**Adult Dental Copay Plan**
	Up to Age 19	**Age 19 and Older**
Actuarial Value	83.0%	Not Calculated
Individual Deductible (waived for Diagnostic & Preventive)	$0	$0
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)	$0	$0
Individual Out of Pocket Maximum	$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	$700	Not Applicable
Office Copay	$0	$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)	None	None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)	None	None

Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Diagnostic & Preventive	Oral Exam	$0		$0	
	Preventive - Cleaning	$0		$0	
	Preventive - X-ray	$0		$0	
	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	
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	$300		$300	
	Gingivectomy per Quad	$150		$150	
	Extraction- Single Tooth Exposed Root or Erupted	$65		$65	
	Extraction - Complete Bony	$160		$160	
	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 in-network 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.

COVERED CALIFORNIA™

2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits and Coverage

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

	Family Dental Plan	
	Pediatric Dental EHB Coinsurance Plan	**Adult Dental Coinsurance Plan**
	Up to Age 19	**Age 19 and Older**
Actuarial Value	86.8%	Not Calculated
Individual Deductible (waived for Diagnostic & Preventive)	$65 In Network/ $65 Out of Network	$50 In Network/ $50 Out of Network
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)	$130 In Network/ $130 Out of Network	Not Applicable
Individual Out of Pocket Maximum	$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	$700	Not Applicable
Office Copay	$0	$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)	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
Diagnostic & Preventive	Oral Exam	0%		0%	
	Preventive - Cleaning	0%		0%	
	Preventive - X-ray	0%		0%	
	Sealants per Tooth	0%		Not Covered	
	Topical Fluoride Application	0%		Not Covered	
	Space Maintainers - Fixed	0%		Not Covered	
Basic Services	Amalgam Fill - One Surface	20%	x	20%	x
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	50%	x	50%	x
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted				
	Extraction - Complete Bony				
	Crown - Porcelain with Metal				
Orthodontia	Medically Necessary Orthodontia	50%	x	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 in-network 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.

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT (REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

ECONOMIC IMPACT STATEMENT

DEPARTMENT NAME	CONTACT PERSON	EMAIL ADDRESS	TELEPHONE NUMBER
California Health Benefit Exchange	Brandon Ross	brandon.ross@covered.ca	916-228-8281

DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400	NOTICE FILE NUMBER
2015 Standard Benefit Design Rulemaking	Z

A. ESTIMATED PRIVATE SECTOR COST IMPACTS *Include calculations and assumptions in the rulemaking record.*

1. Check the appropriate box(es) below to indicate whether this regulation:

- ☐ a. Impacts business and/or employees
- ☐ b. Impacts small businesses
- ☐ c. Impacts jobs or occupations
- ☐ d. Impacts California competitiveness
- ☐ e. Imposes reporting requirements
- ☐ f. Imposes prescriptive instead of performance
- ☐ g. Impacts individuals
- ☐ h. None of the above (Explain below): _____

If any box in Items 1 a through g is checked, complete this Economic Impact Statement.
If box in Item 1.h. is checked, complete the Fiscal Impact Statement as appropriate.

2. The _____ (Agency/Department) estimates that the economic impact of this regulation (which includes the fiscal impact) is:

- ☐ Below $10 million
- ☐ Between $10 and $25 million
- ☐ Between $25 and $50 million
- ☐ Over $50 million *[If the economic impact is over $50 million, agencies are required to submit a Standardized Regulatory Impact Assessment as specified in Government Code Section 11346.3(c)]*

3. Enter the total number of businesses impacted: _____

Describe the types of businesses (Include nonprofits): _____

Enter the number or percentage of total businesses impacted that are small businesses: _____

4. Enter the number of businesses that will be created: _____ 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 impacted: _____

_____

7. Will the regulation affect the ability of California businesses to compete with other states by making it more costly to produce goods or services here? ☐ YES ☐ NO

If YES, explain briefly: _____

_____

_____

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 assumptions in the rulemaking record.*

1. What are the total statewide dollar costs that businesses and individuals may incur to comply with this regulation over its lifetime? $ _____

   a. Initial costs for a small business: $ _____ Annual ongoing costs: $ _____ Years: _____

   b. Initial costs for a typical business: $ _____ Annual ongoing costs: $ _____ Years: _____

   c. Initial costs for an individual: $ _____ Annual ongoing costs: $ _____ Years: _____

   d. Describe other economic costs that may occur: _____

2. If multiple industries are impacted, enter the share of total costs for each industry: _____

3. If the regulation imposes reporting requirements, enter the annual costs a typical business may incur to comply with these requirements. *Include the dollar costs to do programming, record keeping, reporting, and other paperwork, whether or not the paperwork must be submitted.* $ _____

4. Will this regulation directly impact housing costs? ☐ YES ☐ NO

   If YES, enter the annual dollar cost per housing unit: $ _____

   Number of units: _____

5. Are there comparable Federal regulations? ☐ YES ☐ NO

   Explain the need for State regulation given the existence or absence of Federal regulations: _____

   Enter any additional costs to businesses and/or individuals that may be due to State - Federal differences: $ _____

C. ESTIMATED BENEFITS *Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.*

1. Briefly summarize the benefits of the regulation, which may include among others, the health and welfare of California residents, worker safety and the State's environment: _____

2. Are the benefits the result of: ☐ specific statutory requirements, or ☐ goals developed by the agency based on broad statutory authority?

   Explain: _____

3. What are the total statewide benefits from this regulation over its lifetime? $ _____

4. Briefly describe any expansion of businesses currently doing business within the State of California that would result from this regulation: _____

D. ALTERNATIVES TO THE REGULATION *Include calculations and assumptions in the rulemaking record. Estimation of the dollar value of benefits is not specifically required by rulemaking law, but encouraged.*

1. List alternatives considered and describe them below. If no alternatives were considered, explain why not: _____

ECONOMIC IMPACT STATEMENT (CONTINUED)

2. Summarize the total statewide costs and benefits from this regulation and each alternative considered:

   Regulation: Benefit: $ _____ Cost: $ _____

   Alternative 1: Benefit: $ _____ Cost: $ _____

   Alternative 2: Benefit: $ _____ Cost: $ _____

3. Briefly discuss any quantification issues that are relevant to a comparison of estimated costs and benefits for this regulation or alternatives: _____

4. Rulemaking law requires agencies to consider performance standards as an alternative, if a regulation mandates the use of specific technologies or equipment, or prescribes specific actions or procedures. Were performance standards considered to lower compliance costs? ☐ YES ☐ NO

   Explain: _____

E. MAJOR REGULATIONS *Include calculations and assumptions in the rulemaking record.*

California Environmental Protection Agency (Cal/EPA) boards, offices and departments are required to submit the following (per Health and Safety Code section 57005). Otherwise, skip to E4.

1. Will the estimated costs of this regulation to California business enterprises **exceed $10 million**? ☐ YES ☐ NO

If YES, complete E2. and E3
If NO, skip to E4

2. Briefly describe each alternative, or combination of alternatives, for which a cost-effectiveness analysis was performed:

   Alternative 1: _____

   Alternative 2: _____

   (Attach additional pages for other alternatives)

3. For the regulation, and each alternative just described, enter the estimated total cost and overall cost-effectiveness ratio:

   Regulation: Total Cost $ _____ Cost-effectiveness ratio: $ _____

   Alternative 1: Total Cost $ _____ Cost-effectiveness ratio: $ _____

   Alternative 2: Total Cost $ _____ Cost-effectiveness ratio: $ _____

4. Will the regulation subject to OAL review have an estimated economic impact to business enterprises and individuals located in or doing business in California exceeding $50 million in any 12-month period between the date the major regulation is estimated to be filed with the Secretary of State through12 months after the major regulation is estimated to be fully implemented?

   ☐ YES ☐ NO

   If YES, agencies are required to submit a Standardized Regulatory Impact Assessment (SRIA) as specified in Government Code Section 11346.3(c) and to include the SRIA in the Initial Statement of Reasons.

5. Briefly describe the following:

   The increase or decrease of investment in the State: _____

   The incentive for innovation in products, materials or processes: _____

   The benefits of the regulations, including, but not limited to, benefits to the health, safety, and welfare of California residents, worker safety, and the state's environment and quality of life, among any other benefits identified by the agency: _____

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

ECONOMIC AND FISCAL IMPACT STATEMENT

(REGULATIONS AND ORDERS)

STD. 399 (REV. 12/2013)

FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT *Indicate appropriate boxes 1 through 6 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.*

☐ 1. Additional expenditures in the current State Fiscal Year which are reimbursable by the State. (Approximate)
(Pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code).

$ _____

☐ a. Funding provided in _____

Budget Act of _____ or Chapter _____, Statutes of _____

☐ b. Funding will be requested in the Governor's Budget Act of _____

Fiscal Year: _____

☐ 2. Additional expenditures in the current State Fiscal Year which are NOT reimbursable by the State. (Approximate)
(Pursuant to Section 6 of Article XIII B of the California Constitution and Sections 17500 et seq. of the Government Code).

$ _____

Check reason(s) this regulation is not reimbursable and provide the appropriate information:

☐ a. Implements the Federal mandate contained in _____

☐ b. Implements the court mandate set forth by the _____ Court.

Case of: _____ vs. _____

☐ c. Implements a mandate of the people of this State expressed in their approval of Proposition No. _____

Date of Election: _____

☐ d. Issued only in response to a specific request from affected local entity(s).

Local entity(s) affected: _____

_____

☐ e. Will be fully financed from the fees, revenue, etc. from: _____

Authorized by Section: _____ of the _____ Code;

☐ f. Provides for savings to each affected unit of local government which will, at a minimum, offset any additional costs to each;

☐ g. Creates, eliminates, or changes the penalty for a new crime or infraction contained in _____

☐ 3. Annual Savings. (approximate)

$ _____

☐ 4. No additional costs or savings. This regulation makes only technical, non-substantive or clarifying changes to current law regulations.

☒ 5. No fiscal impact exists. This regulation does not affect any local entity or program.

☐ 6. Other. Explain _____

_____

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 calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.*

☐ 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)

$ _____

☒ 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 through 4 and attach calculations and assumptions of fiscal impact for the current year and two subsequent Fiscal Years.*

☐ 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.

☒ 4. Other. Explain Estimated cost impact to the Federal Funds (Grant) is $332,000 in fiscal year 2013-14.

This proposal has no impact on the General Fund. Please see the attachment for additional detail.

FISCAL OFFICER SIGNATURE	DATE
	4-1-14

The signature attests that the agency has completed the STD. 399 according to the instructions in SAM sections 6601-6616, and understands the impacts of the proposed rulemaking. State boards, offices, or departments not under an Agency Secretary must have the form signed by the highest ranking official in the organization.

AGENCY SECRETARY	DATE
	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

2015 Standard Benefit Design Rulemaking
Std 399

Attachment

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

	Cost (per classification)							
Classification	**Salary Cost[1/]**	**Benefits[2/]**	**Total PS**	**OE&E[3/]**	**PS + OE&E**	**Staffing Level[4/]**	**Total Cost**	
C.E.A Level B @ 10%	$ 3,286	$ 1,282	**$ 4,568**	$ 467	**$ 5,035**	1.0	$	5,035
Staff Services Manager I (SSM I) @ 30%	$ 6,834	$ 2,665	**$ 9,499**	$ 1,400	**$ 10,899**	2.0	$	21,798
Staff Services Manager II (SSM II) @ 20%	$ 5,002	$ 1,951	**$ 6,953**	$ 933	**$ 7,886**	1.0	$	7,886
Research Program Specialist II (RPS II) @ 40%	$ 9,563	$ 3,730	**$ 13,293**	$ 1,867	**$ 15,160**	1.0	$	15,160
Assoc. Gov. Program Analyst (AGPA) @ 50%	$ 9,908	$ 3,864	**$ 13,772**	$ 2,333	**$ 16,105**	3.0	$	48,316
Total	$ 34,593	$ 13,492	**$ 48,085**	$ 7,000	**$ 55,085**	8.0	**$**	**98,195**

1. 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.
2. Benefits calculated via standard benefit rate (39%).
3. OE&E includes annual standard complement at $14,000, prorated based on the same parameters as salary.
4. Staffing level and associated classifications provided by program.
5. (4) month measurement period is 02/01/14 - 05/31/2014.

Contract Costs

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

Total Summary

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