State of California
Office of Administrative Law

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 6432
Amend sections:
Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 11346.1 and 11349.6

OAL Matter Number: 2015-0603-02

OAL Matter Type: Emergency Readopt (EE)

This action re-adopts and amends the 2016 Standard Benefit Design, which standardizes the way health insurers design their health plans.

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

This emergency regulatory action is effective on 6/15/2015 and will expire on 2/22/2017. The Certificate of Compliance for this action is due no later than 2/21/2017.

Date: June 15, 2015

Mark Storm
Senior Attorney

For: DEBRA M. CORNEZ
Director

Original: Peter Lee
Copy: Andrea Rosen

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

EMERGENCY

(See instructions on reverse)

STD. 400 (REV. 01-2013)

For use by Secretary of State only

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z-		2015-0603-02EE

For use by Office of Administrative Law (OAL) only

JUN LW 2015 MAY -3 PM 3:59

OFFICE OF ADMINISTRATIVE LAW

NOTICE

REGULATIONS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California
JUN 15 2015
2:27 PM

AGENCY WITH RULEMAKING AUTHORITY: California Health Benefit Exchange

AGENCY FILE NUMBER (If any):

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

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

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

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	☐ Approved as Submitted ☐ Approved as Modified ☐ Disapproved/ Withdrawn		

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S): 2016 Standard Benefit Design

1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S): 2015-0209-03E; 2015-0312-01EE

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

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT	AMEND	REPEAL
TITLE(S): 10	6432		

3. TYPE OF FILING

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

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

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

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

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

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

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Andrea Rosen	(916) 228-8343		andrea.rosen@covered.ca.gov

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

SIGNATURE OF AGENCY HEAD OR DESIGNEE

DATE: 5-21-2015 per agency request

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

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

JUN 15 2015

Office of Administrative Law

STATE OF CALIFORNIA

NOTICE PUBLICATION/REGULATIONS SUBMISSION

STD. 400 (REV. 01-2013) (REVERSE)

INSTRUCTIONS FOR PUBLICATION OF NOTICE AND SUBMISSION OF REGULATIONS

Use the form STD. 400 for submitting notices for publication and regulations for Office of Administrative Law (OAL) review.

ALL FILINGS

Enter the name of the agency with the rulemaking authority and agency's file number, if any.

NOTICES

Complete Part A when submitting a notice to OAL for publication in the California Regulatory Notice Register. Submit two (2) copies of the STD. 400 with four (4) copies of the notice and, if a notice of proposed regulatory action, one copy each of the complete text of the regulations and the statement of reasons. Upon receipt of the notice, OAL will place a number in the box marked "Notice File Number." If the notice is approved, OAL will return the STD. 400 with a copy of the notice and will check "Approved as Submitted" or "Approved as Modified." If the notice is disapproved or withdrawn, that will also be indicated in the space marked "Action on Proposed Notice." Please submit a new form STD. 400 when resubmitting the notice.

REGULATIONS

When submitting regulations to OAL for review, fill out STD. 400, Part B. Use the form that was previously submitted with the notice of proposed regulatory action which contains the "Notice File Number" assigned, or, if a new STD. 400 is used, please include the previously assigned number in the box marked "Notice File Number." In filling out Part B, be sure to complete the certification including the date signed, the title and typed name of the signatory. The following must be submitted when filing regulations: seven (7) copies of the regulations with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification) and the complete rulemaking file with index and sworn statement. (See Gov. Code § 11347.3 for rulemaking file contents.)

RESUBMITTAL OF DISAPPROVED OR WITHDRAWN REGULATIONS

When resubmitting previously disapproved or withdrawn regulations to OAL for review, use a new STD. 400 and fill out Part B, including the signed certification. Enter the OAL file number(s) of all previously disapproved or withdrawn filings in the box marked "All Previous Related OAL Regulatory Action Number(s)" (box lb. of Part B). Submit seven (7) copies of the regulation to OAL with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification). Be sure to include an index, sworn statement, and (if returned to the agency) the complete rulemaking file. (See Gov. Code §§ 11349.4 and 11347.3 for more specific requirements.)

EMERGENCY REGULATIONS

Fill out only Part B, including the signed certification, and submit seven (7) copies of the regulations with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification). (See Gov. Code §11346.1 for other requirements.)

NOTICE FOLLOWING EMERGENCY ACTION

When submitting a notice of proposed regulatory action after an emergency filing, use a new STD. 400 and complete Part A and insert the OAL file number(s) for the original emergency filing(s) in the box marked "All Previous Related OAL Regulatory Action Number(s)" (box 1b. of Part B). OAL will return the STD. 400 with the notice upon approval or disapproval. If the notice is disapproved, please fill out a new form when resubmitting for publication.

CERTIFICATE OF COMPLIANCE

When filing the certificate of compliance for emergency regulations, fill out Part B, including the signed certification, on the form that was previously submitted with the notice. If a new STD. 400 is used, fill in Part B including the signed certification, and enter the previously assigned notice file number in the box marked "Notice File Number" at the top of the form. The materials indicated in these instructions for "REGULATIONS" must also be submitted.

EMERGENCY REGULATIONS - READOPTION

When submitting previously approved emergency regulations for readoption, use a new STD. 400 and fill out Part B, including the signed certification, and insert the OAL file number(s) related to the original emergency filing in the box marked "All Previous Related OAL Regulatory Action Number (s)" (box 1b. of Part B).

CHANGES WITHOUT REGULATORY EFFECT

When submitting changes without regulatory effect pursuant to California Code of Regulations, Title 1, section 100, complete Part B, including marking the appropriate box in both B.3. and B.5.

ABBREVIATIONS

Cal. Code Regs. - California Code of Regulations
Gov. Code - Government Code
SAM - State Administrative Manual

For questions regarding this form or the procedure for filing notices or submitting regulations to OAL for review, please contact the Office of Administrative Law Reference Attorney at (916) 323-6815.

Title 10, California Code of Regulations

Re-adopt Section 6432:

SECTION 6432: 2016 STANDARD BENEFIT PLAN DESIGNS

(a) For plan year and calendar year 2016, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2016 Standard Benefit Plan Designs dated ~~January 29, 2015~~ May 21, 2015 which are 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)

2016 Standard Benefit Plan Designs

~~January 29, 2015~~

May 21, 2015

2016 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 16~~May 21, 2015

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	
[redacted]	88.5%		89.5%	
[redacted]	No		No	
[redacted]	$0		$0	
[redacted]	$0		$0	
[redacted]	$0 / $0 / $0		$0 / $0 / $0	
[redacted]	$0 / $0 / $0		$0 / $0 / $0	
[redacted]	$4,000		$4,000	
[redacted]	$8,000		$8,000	
[redacted]	N/A		N/A	
[redacted]	N/A		N/A	

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
[redacted]	Primary care visit to treat an injury, illness, or condition		$20		$20	
	Other practitioner office visit		$20		$20	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
[redacted]	Tier 1		$5		$5	
	Tier 2		$15		$15	
	Tier 3		$25		$25	
	Tier 4		10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%		$40	
	Outpatient visit		10%		10%	
[redacted]	Emergency room facility fee (waived if admitted)		$150		$150	
	Emergency room physician fee (waived if admitted)		10%		No charge	
	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%		$40	
Mental health, Behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$20		$20	
	Mental/Behavioral health other outpatient items and services		$20		$20	
	Mental/Behavioral health inpatient facility fee (e.g hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee		10%		$40	
	Substance Use disorder outpatient office visits		$20		$20	
	Substance Use disorder other outpatient items and services		$20		$20	
	Substance Use inpatient facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee		10%		$40	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		$40	
Habilitation services for other medical 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 charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No charge		No charge	
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 [redacted]	Medically necessary orthodontics		50%		$1,000	

See endnotes.

2016 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 16~~May 21, 2015

Summary of Benefits and Coverage

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

	Gold Coinsurance Plan	Gold Copay Plan
	80.2%	81.0%
	No	No
	$0	$0
	$0	$0
	$0 / $0 / $0	$0 / $0 / $0
	$0 / $0 / $0	$0 / $0 / $0
	$6,200	$6,200
	$12,400	$12,400
	N/A	N/A
	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition		$35		$35	
	Other practitioner office visit		$35		$35	
	Specialist visit		$55		$55	
	Preventive care/ screening/ immunization		No charge		No charge	
	Laboratory Tests		$35		$35	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
	Tier 1		$15		$15	
	Tier 2		$50		$50	
	Tier 3		$70		$70	
	Tier 4		20% up to $250 per script		20% up to $250 per script	
	Surgery facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%		$55	
	Outpatient visit		20%		20%	
	Emergency room facility fee (waived if admitted)		$250		$250	
	Emergency room physician fee (waived if admitted)		20%		No charge	
	Emergency medical transportation		$250		$250	
	Urgent care		$60		$60	
	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%		$55	
	Mental/Behavioral health outpatient office visits		$35		$35	
	Mental/Behavioral health other outpatient items and services		$35		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee		20%		$55	
	Substance Use disorder outpatient office visits		$35		$35	
	Substance Use disorder other outpatient items and services		$35		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee		20%		$55	
	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%		$55	
	Home health care		20%		$30	
	Outpatient Rehabilitation services		$35		$35	
	Outpatient Habilitation services		$35		$35	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No charge		No charge	
	Amalgam Fill - 1 Surface		20%		$25	
	Root Canal- Molar		50%		$300	
	Gingivectomy per Quad				$160	
	Extraction- Single Tooth Exposed Root or Erupted				$65	
	Extraction- Complete Bony				$160	
	Porcelain with Metal Crown				$300	
	Medically necessary orthodontics		50%		$1,000	

See endnotes.

2016 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 16~~May 21, 2015

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	Individual Silver Plan
Actuarial Value - AV Calculator	70.4%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,250 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,500 / $500 / $0
Individual Out-of-pocket maximum	$6,250
Family Out-of-pocket maximum	$12,500
HSA plan: Sub-family coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$45	
	Other practitioner office visit		$45	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$65	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$50	Pharmacy deductible
	Tier 3		$70	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Emergency room services	Emergency room facility fee (waived if admitted)		$250	X
	Emergency room physician fee (waived if admitted)		$50	X
	Emergency medical transportation		$250	X
Urgent care	Urgent care		$90	
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 office visits		$45	
	Mental/Behavioral health other outpatient items and services		$45	
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)		20%	X
	Mental/Behavioral health inpatient physician/surgeon fee		20%	X
	Substance Use disorder outpatient office visits		$45	
	Substance Use disorder other outpatient items and services		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician/surgeon fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$45	
	Outpatient Rehabilitation services		$45	
	Outpatient Habilitation services		$45	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye exam	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	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.

2016 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 16~~May 21, 2015

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 - As applicable	~~74.7%~~ 71.7%	~~74.4%~~ 71.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$1,500 / ~~$500~~ $250 / $0	$1,500 / ~~$500~~ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$3,000 / ~~$1,000~~ $500 / $0	$3,000 / ~~$1,000~~ $500 / $0
Individual Out-of-pocket maximum	$6,500	$6,500
Family Out-of-pocket maximum	$13,000	$13,000
HSA plan: Individual coverage deductible	N/A	N/A
HSA family plan: Individual embedded	N/A	N/A

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 to treat an injury, illness, or condition		$45		$45	
	Other practitioner office visit		$45		$45	
	Specialist visit		$70		$70	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$35		$35	
	X-rays and Diagnostic Imaging		$65		$65	
	Imaging (CT/PET scans, MRIs)		20%	X	$250	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55	Pharmacy deductible	$55	Pharmacy deductible
	Tier 3		$75	Pharmacy deductible	$75	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
	Outpatient visit		20%		20%	
Emergency services	Emergency room facility fee (waived if admitted)		$250	X	$250	X
	Emergency room physician fee (waived if admitted)		$50	X	$50	X
	Emergency medical transportation		$250	X	$250	X
Urgent care	Urgent care		$90		$90	
Hospitalization	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$45		$45	
	Mental/Behavioral health other outpatient items and services		$45		$45	
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee		20%	X	20%	X
	Substance Use disorder outpatient office visits		$45		$45	
	Substance Use disorder other outpatient items and services		$45		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Substance use disorder inpatient physician/surgeon fee		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Rehabilitative services	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 charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No charge		No charge	
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 Orthodontia	Medically necessary orthodontics		50%		$1,000	

See endnotes.

2016 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 16~~May 21, 2015

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	SHOF Silver HSA Plan
Actuarial Value - AV Calculator	70.5%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out-of-pocket maximum	$6,250
Family Out-of-pocket maximum	$12,500
HSA plan: Individual coverage deductible	$2,000
HSA family plan: individual deductible	~~See endnote~~ $2,600

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	20%	X
	Other practitioner office visit	20%	X
	Specialist visit	20%	X
	Preventive care/ screening/ immunization	No charge	
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	Tier 1	20%	X
	Tier 2	20%	X
	Tier 3	20%	X
	Tier 4	20%	X
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees	20%	X
	Outpatient visit	20%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X
	Emergency room physician fee (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 office visits	20%	X
	Mental/Behavioral health other outpatient items and services	20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
	Substance Use disorder outpatient office visits	20%	X
	Substance Use disorder other outpatient items and services	20%	X
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services — Hospital	20%	X
	Delivery and all inpatient services — 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	0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge	
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	50%	
Child Orthodontia	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 Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value / AV Calculator	93.8%	~~86.8%~~86.9%
Plan accepts individual + dependent?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$75 / $0 / $0	$550 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$150 / $0 / $0	$1,100 / $100 / $0
Individual Out-of-pocket maximum	$2,250	$2,250
Family Out-of-pocket maximum	$4,500	$4,500
HSA plan: Authority coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Healthcare provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$5		$15	
	Other practitioner office visit		$5		$15	
	Specialist visit		$8		$25	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		~~$8~~		~~$15~~	
	X-rays and Diagnostic Imaging		~~$8~~		~~$25~~	
	Imaging (CT/PET scans, MRIs)		~~$50~~		~~$100~~	
Drugs to treat illness or condition	Tier 1		$3		$5	
	Tier 2		$10		$20	Pharmacy deductible
	Tier 3		$15		$35	Pharmacy deductible
	Tier 4		10% up to $150 per script		15% up to $150 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$30	X	$75	X
	Emergency room physician fee (waived if admitted)		$25	X	$40	X
	Emergency medical transportation		$30	X	$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%	X	15%	X
	Physician/surgeon fee		10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$5		$15	
	Mental/Behavioral health other outpatient items and services		$5		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	X	15%	X
	Mental/Behavioral health inpatient physician/surgeon fee		10%	X	15%	X
	Substance Use disorder outpatient office visits		$5		$15	
	Substance Use disorder other outpatient items and services		$5		$15	
	Substance Use inpatient facility fee (e.g. hospital room)		10%	X	15%	X
	Substance use disorder inpatient physician/surgeon fee		10%	X	15%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care		~~$3~~		~~$15~~	
	Outpatient Rehabilitation services		~~$5~~		~~$15~~	
	Outpatient Habilitation services		~~$5~~		~~$15~~	
	Skilled nursing care		10%	X	15%	X
	Durable medical equipment		~~10%~~		~~15%~~	
	Hospice service		~~No charge~~		~~No charge~~	
Child eye care	Eye exam		~~No charge~~		~~No charge~~	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No charge		No charge	
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown		50%		50%	
Child Orthodontics	Medically necessary orthodontics		50%		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL
[illegible]	72.8%
[illegible]	Yes, Medical/Pharmacy
[illegible]	N/A
[illegible]	N/A
[illegible]	$1,900 / $250 / $0
[illegible]	$3,800 / $500 / $0
[illegible]	$5,450
[illegible]	$10,900
[illegible]	N/A
[illegible]	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
[illegible]	Primary care visit to treat an injury, illness, or condition		$40	
	Other practitioner office visit		$40	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
[illegible]	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
[illegible]	Tier 1		$15	
	Tier 2		$45	Pharmacy deductible
	Tier 3		$70	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
[illegible]	Surgery facility fee (e.g. ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
[illegible]	Emergency room facility fee (waived if admitted)		$250	X
	Emergency room physician fee (waived if admitted)		$50	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
[illegible]	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
[illegible]	Mental/Behavioral health outpatient office visits		$40	
	Mental/Behavioral health other outpatient items and services		$40	
	Mental/Behavioral health inpatient facility fee (e.g hospital room)		20%	X
	Mental/Behavioral health inpatient physician/surgeon fee		20%	X
	Substance Use disorder outpatient office visits		$40	
	Substance Use disorder other outpatient items and services		$40	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician/surgeon fee		20%	X
[illegible]	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
[illegible]	Home health care		$40	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
[illegible]	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
[illegible]	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
[illegible]	Amalgam Fill - 1 Surface		20%	
[illegible]	Root Canal- Molar		50%	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
[illegible]	Medically necessary orthodontics		50%	

See endnotes.

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

	Bronze Plan	Bronze HSA Plan
	~~61.3%~~ 61.1%	61.1%
	Yes, ~~integrated~~ Medical/Pharmacy	Yes, integrated
	~~$6,600 integrated~~ N/A	$4,500 integrated
	~~$13,200 integrated~~ N/A	$9,000 integrated
	~~N/A~~6,000 / ~~5,000~~ / $0	N/A
	~~N/A~~12,000 / ~~11,000~~ / $0	N/A
	$6,600	$6,500
	$13,000	$13,000
	N/A	$4,500
	N/A	$4,500

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Healthcare provider's office or other visits	Primary care visit to treat an injury, illness, or condition	$70	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	$70	After 1st three non-preventive visits	40%	X
	Specialist visit	$90	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$40		40%	X
	X-rays and Diagnostic Imaging	~~0%~~100%	X	40%	X
	Imaging (CT/PET scans, MRIs)	~~0%~~100%	X	40%	X
Drugs to treat illness or condition	Tier 1	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
	Tier 2	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
	Tier 3	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
	Tier 4	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
Outpatient services	Surgery facility fee (e.g. ASC)	~~0%~~100%	X	40%	X
	Physician/surgeon fees	~~0%~~100%	X	40%	X
	Outpatient visit	~~0%~~100%	X	40%	X
Emergency services	Emergency room facility fee (waived if admitted)	~~0%~~100%	X	40%	X
	Emergency room physician fee (waived if admitted)	~~0%~~100%	X	40%	X
	Emergency medical transportation	~~0%~~100%	X	40%	X
Urgent care	Urgent care	$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	~~0%~~100%	X	40%	X
	Physician/surgeon fee	~~0%~~100%	X	40%	X
Mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient office visits	$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services	$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)	~~0%~~100%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee	~~0%~~100%	X	40%	X
	Substance Use disorder outpatient office visits	$70	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	$70	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	~~0%~~100%	X	40%	X
	Substance use disorder inpatient physician/surgeon fee	~~0%~~100%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services: Hospital	~~0%~~100%	X	40%	X
	Delivery and all inpatient services: Professional	~~0%~~100%	X	40%	X
Rehabilitative services	Home health care	~~0%~~100%	X	40%	X
	Outpatient Rehabilitation services	$70		40%	X
	Outpatient Habilitation services	$70		40%	X
	Skilled nursing care	~~0%~~100%	X	40%	X
Habilitative services	Durable medical equipment	~~0%~~100%	X	40%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		20%	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	50%		50%	
Child Orthodontics	Medically necessary orthodontics	50%		50%	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan
Actuarial Value - AV Calculator			
Plan design includes a deductible?			Yes, integrated
Integrated individual deductible			$6,850 integrated
Integrated Family deductible			$13,700 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental			N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental			N/A
Individual Out-of-pocket maximum			$6,850
Family Out-of-pocket maximum			$13,700
HSA plan: Self-only coverage deductible			N/A
HSA family plan: Individual deductible			N/A
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
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	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
Outpatient services	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
Need immediate medical attention	Emergency room facility fee (waived if admitted)		0%	X
	Emergency room physician fee (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 office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g hospital room)		0%	X
	Mental/Behavioral health inpatient physician/surgeon fee		0%	X
	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)		0%	X
	Substance use disorder inpatient physician/surgeon fee		0%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	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		0%	X
Child eye exam	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	X
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No charge	
Child Dental Basic Services	Amalgam Fill - 1 Surface		0%	X
Child Dental Major Services	Root Canal- Molar		0%	X
	Gingivectomy per Quad			X
	Extraction- Single Tooth Exposed Root or Erupted			X
	Extraction- Complete Bony			X
	Porcelain with Metal Crown			X
Child Orthodontia	Medically necessary orthodontics		0%	X

See endnotes.

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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	88.5%	89.5%
Plan design includes a deductible?	No	No
Integrated Individual deductible	$0	$0
Integrated Family deductible	$0	$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$0 / $0 / $0
Individual Out-of-pocket maximum	$4,000	$4,000
Family Out-of-pocket maximum	$8,000	$8,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

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 to treat an injury, illness, or condition	$20		$20	
	Other practitioner office visit	$20		$20	
	Specialist visit	$40		$40	
	Preventive care/ screening/ immunization	No charge		No charge	
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	Tier 1	$5		$5	
	Tier 2	$15		$15	
	Tier 3	$25		$25	
	Tier 4	10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		$250	
	Physician/surgeon fees	10%		$40	
	Outpatient visit	10%		10%	
Emergency services	Emergency room facility fee (waived if admitted)	$150		$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
	Emergency medical transportation	$150		$150	
Urgent care	Urgent care	$40		$40	
Hospitalization	Facility fee (e.g. hospital room)	10%		$250 per day up to 5 days	
	Physician/surgeon fee	10%		$40	
Mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient office visits	$20		$20	
	Mental/Behavioral health other outpatient items and services	$20		$20	
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)	10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	10%		$40	
	Substance Use disorder outpatient office visits	$20		$20	
	Substance Use disorder other outpatient items and services	$20		$20	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		$250 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	10%		$40	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services — Hospital	10%		$250 per day up to 5 days	
	Delivery and all inpatient services — Professional	10%		$40	
Rehabilitative services	Home health care	10%		$20	
	Outpatient Rehabilitation services	$20		$20	
	Outpatient Habilitation services	$20		$20	
Skilled nursing facility	Skilled nursing care	10%		$150 per day up to 5 days	
Durable medical equipment	Durable medical equipment	10%		10%	
Hospice service	Hospice service	No charge		No charge	
Child eye exam	Eye exam	No charge		No charge	
Child glasses	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child dental checkup	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child dental basic services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
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	
[redacted]		80.2%		81.0%	
[redacted]		No		No	
[redacted]		$0		$0	
[redacted]		$0		$0	
[redacted]		$0 / $0 / $0		$0 / $0 / $0	
[redacted]		$0 / $0 / $0		$0 / $0 / $0	
[redacted]		$6,200		$6,200	
[redacted]		$12,400		$12,400	
[redacted]		N/A		N/A	
[redacted]		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
[redacted]	Primary care visit to treat an injury, illness, or condition	$35		$35	
	Other practitioner office visit	$35		$35	
	Specialist visit	$55		$55	
	Preventive care/ screening/ immunization	No charge		No charge	
[redacted]	Laboratory Tests	$35		$35	
	X-rays and Diagnostic Imaging	$50		$50	
	Imaging (CT/PET scans, MRIs)	20%		$250	
[redacted]	Tier 1	$15		$15	
	Tier 2	$50		$50	
	Tier 3	$70		$70	
	Tier 4	20% up to $250 per script		20% up to $250 per script	
[redacted]	Surgery facility fee (e.g., ASC)	20%		$600	
	Physician/surgeon fees	20%		$55	
	Outpatient visit	20%		20%	
[redacted]	Emergency room facility fee (waived if admitted)	$250		$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
	Emergency medical transportation	$250		$250	
	Urgent care	$60		$60	
[redacted]	Facility fee (e.g. hospital room)	20%		$600 per day up to 5 days	
	Physician/surgeon fee	20%		$55	
[redacted]	Mental/Behavioral health outpatient office visits	$35		$35	
	Mental/Behavioral health other outpatient items and services	$35		$35	
	Mental/Behavioral health inpatient facility fee (e.g hospital room)	20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	20%		$55	
	Substance Use disorder outpatient office visits	$35		$35	
	Substance Use disorder other outpatient items and services	$35		$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		$600 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	20%		$55	
[redacted]	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services — Hospital	20%		$600 per day up to 5 days	
	Delivery and all inpatient services — Professional	20%		$55	
[redacted]	Home health care	20%		$30	
	Outpatient Rehabilitation services	$35		$35	
	Outpatient Habilitation services	$35		$35	
	Skilled nursing care	20%		$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
[redacted]	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
[redacted]	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
[redacted]	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
[redacted]	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	
[redacted]	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.	Individual Silver Plan
[redacted]	70.4%
[redacted]	Yes, Medical/Pharmacy
[redacted]	N/A
[redacted]	N/A
[redacted]	$2,250 / $250 / $0
[redacted]	$4,500 / $500 / $0
[redacted]	$6,250
[redacted]	$12,500
[redacted]	N/A
[redacted]	N/A

Common Medical Event	Service Type	Member Cost Share	Services deductible applies
[redacted]	Primary care visit to treat an injury, illness, or condition	$45	
	Other practitioner office visit	$45	
	Specialist visit	$70	
	Preventive care/ screening/ immunization	No charge	
[redacted]	Laboratory Tests	$35	
	X-rays and Diagnostic Imaging	$65	
	Imaging (CT/PET scans, MRIs)	$250	
[redacted]	Tier 1	$15	
	Tier 2	$50	Pharmacy deductible
	Tier 3	$70	Pharmacy deductible
	Tier 4	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
[redacted]	Surgery facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Outpatient visit	20%	
[redacted]	Emergency room facility fee (waived if admitted)	$250	X
	Emergency room physician fee (waived if admitted)	$50	X
	Emergency medical transportation	$250	X
	Urgent care	$90	
[redacted]	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
[redacted]	Mental/Behavioral health outpatient office visits	$45	
	Mental/Behavioral health other outpatient items and services	$45	
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
[redacted]	Substance Use disorder outpatient office visits	$45	
	Substance Use disorder other outpatient items and services	$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X
[redacted]	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services — Hospital	20%	X
	Delivery and all inpatient services — Professional	20%	X
[redacted]	Home health care	$45	
	Outpatient Rehabilitation services	$45	
	Outpatient Habilitation services	$45	
	Skilled nursing care	20%	X
[redacted]	Durable medical equipment	20%	
	Hospice service	No charge	
[redacted]	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
[redacted]	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered	
[redacted]	Amalgam Fill - 1 Surface	Not Covered	
[redacted]	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered	
[redacted]	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.		SHOP Silver HSA Plan
[illegible]		70.5%
[illegible]		Yes, integrated
[illegible]		$2,000 integrated
[illegible]		$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
Family deductible, NOT integrated: [illegible]		N/A
[illegible]		$6,250
[illegible]		$12,500
[illegible]		$2,000
[illegible]		~~See endnote~~ $2,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
[illegible]	Primary care visit to treat an injury, illness, or condition		20%	X
	Other practitioner office visit		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No charge	
[illegible]	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
[illegible]	Tier 1		20%	X
	Tier 2		20%	X
	Tier 3		20%	X
	Tier 4		20%	X
[illegible]	Surgery facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
	Outpatient visit		20%	X
[illegible]	Emergency room facility fee (waived if admitted)		20%	X
	Emergency room physician fee (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
[illegible]	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
[illegible]	Mental/Behavioral health outpatient office visits		20%	X
	Mental/Behavioral health other outpatient items and services		20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician/surgeon fee		20%	X
	Substance Use disorder outpatient office visits		20%	X
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician/surgeon fee		20%	X
[illegible]	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
[illegible]	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		0%	X
[illegible]	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
[illegible]	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered	
[illegible]	Amalgam Fill - 1 Surface		Not Covered	
[illegible]	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction - Complete Bony Porcelain with Metal Crown		Not Covered	
[illegible]	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 Plan 100%-150% FPL	Silver Plan 150%-200% FPL
[redacted]	93.8%	~~86.8%~~86.8%
[redacted]	Yes. Medical/Pharmacy	Yes. Medical/Pharmacy
[redacted]	N/A	N/A
[redacted]	N/A	N/A
[redacted]	$75 / $0 / $0	$550 / $50 / $0
[redacted]	$150 / $0 / $0	$1,100 / $100 / $0
[redacted]	$2,250	$2,250
[redacted]	$4,500	$4,500
[redacted]	N/A	N/A
[redacted]	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
[redacted]	Primary care visit to treat an injury, illness or condition	$5		$15	
[redacted]	Other practitioner office visit	$5		$15	
[redacted]	Specialist visit	$8		$25	
[redacted]	Preventive care/ screening/ immunization	No charge		No charge	
[redacted]	Laboratory Tests	$3		$15	
[redacted]	X-rays and Diagnostic Imaging	$8		$25	
[redacted]	Imaging (CT/PET scans, MRIs)	$50		$100	
[redacted]	Tier 1	$3		$5	
[redacted]	Tier 2	$10		$20	Pharmacy deductible
[redacted]	Tier 3	$15		$35	Pharmacy deductible
[redacted]	Tier 4	10% up to $150 per script		15% up to $150 per script after pharmacy deductible	Pharmacy deductible
[redacted]	Surgery facility fee (e.g., ASC)	10%		15%	
[redacted]	Physician/surgeon fees	10%		15%	
[redacted]	Outpatient visit	10%		15%	
[redacted]	Emergency room facility fee (waived if admitted)	$30	X	$75	X
[redacted]	Emergency room physician fee (waived if admitted)	$25	X	$40	X
[redacted]	Emergency medical transportation	$30	X	$75	X
[redacted]	Urgent care	$6		$30	
[redacted]	Facility fee (e.g. hospital room)	10%	X	15%	X
[redacted]	Physician/surgeon fee	10%	X	15%	X
[redacted]	Mental/Behavioral health outpatient office visits	$5		$15	
[redacted]	Mental/Behavioral health other outpatient items and services	$5		$15	
[redacted]	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	X	15%	X
[redacted]	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	X
[redacted]	Substance Use disorder outpatient office visits	$5		$15	
[redacted]	Substance Use disorder other outpatient items and services	$5		$15	
[redacted]	Substance Use inpatient facility fee (e.g. hospital room)	10%	X	15%	X
[redacted]	Substance use disorder inpatient physician/surgeon fee	10%	X	15%	X
[redacted]	Prenatal care and preconception visits	No charge		No charge	
[redacted]	Delivery and all inpatient services — Hospital	10%	X	15%	X
[redacted]	Delivery and all inpatient services — Professional	10%	X	15%	X
[redacted]	Home health care	$3		$15	
[redacted]	Outpatient Rehabilitation services	$5		$15	
[redacted]	Outpatient Habilitation services	$5		$15	
[redacted]	Skilled nursing care	10%	X	15%	X
[redacted]	Durable medical equipment	10%		15%	
[redacted]	Hospice service	No charge		No charge	
[redacted]	Eye exam	No charge		No charge	
[redacted]	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
[redacted]	Oral Exam	Not Covered		Not Covered	
[redacted]	Preventive - Cleaning				
[redacted]	Preventive - X-ray				
[redacted]	Sealants per Tooth				
[redacted]	Topical Fluoride Application				
[redacted]	Space Maintainers - Fixed				
[redacted]	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
[redacted]	Root Canal- Molar	Not Covered		Not Covered	
[redacted]	Gingivectomy per Quad				
[redacted]	Extraction- Single Tooth Exposed Root or Erupted				
[redacted]	Extraction- Complete Bony				
[redacted]	Porcelain with Metal Crown				
[redacted]	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.		Silver Plan 200%-250% FPL	
[illegible]		72.8%	
[illegible]		Yes. Medical/Pharmacy	
[illegible]		N/A	
[illegible]		N/A	
[illegible]		$1,900 / $250 / $0	
[illegible]		$3,800 / $500 / $0	
[illegible]		$5,450	
[illegible]		$10,900	
[illegible]		N/A	
[illegible]		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
[illegible]	Primary care visit to treat an injury, illness, or condition	$40	
[illegible]	Other practitioner office visit	$40	
[illegible]	Specialist visit	$55	
[illegible]	Preventive care/ screening/ immunization	No charge	
[illegible]	Laboratory Tests	$35	
[illegible]	X-rays and Diagnostic Imaging	$50	
[illegible]	Imaging (CT/PET scans, MRIs)	$250	
[illegible]	Tier 1	$15	
[illegible]	Tier 2	$45	Pharmacy deductible
[illegible]	Tier 3	$70	Pharmacy deductible
[illegible]	Tier 4	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
[illegible]	Surgery facility fee (e.g., ASC)	20%	
[illegible]	Physician/surgeon fees	20%	
[illegible]	Outpatient visit	20%	
[illegible]	Emergency room facility fee (waived if admitted)	$250	X
[illegible]	Emergency room physician fee (waived if admitted)	$50	X
[illegible]	Emergency medical transportation	$250	X
[illegible]	Urgent care	$80	
[illegible]	Facility fee (e.g. hospital room)	20%	X
[illegible]	Physician/surgeon fee	20%	X
[illegible]	Mental/Behavioral health outpatient office visits	$40	
[illegible]	Mental/Behavioral health other outpatient items and services	$40	
[illegible]	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X
[illegible]	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
[illegible]	Substance Use disorder outpatient office visits	$40	
[illegible]	Substance Use disorder other outpatient items and services	$40	
[illegible]	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
[illegible]	Substance use disorder inpatient physician/surgeon fee	20%	X
[illegible]	Prenatal care and preconception visits	No charge	
[illegible]	Delivery and all inpatient services – Hospital	20%	X
[illegible]	Delivery and all inpatient services – Professional	20%	X
[illegible]	Home health care	$40	
[illegible]	Outpatient Rehabilitation services	$40	
[illegible]	Outpatient Habilitation services	$40	
[illegible]	Skilled nursing care	20%	X
[illegible]	Durable medical equipment	20%	
[illegible]	Hospice service	No charge	
[illegible]	Eye exam	No charge	
[illegible]	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
[illegible]	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered	
[illegible]	Amalgam Fill - 1 Surface	Not Covered	
[illegible]	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered	
[illegible]	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	
		~~61.3%~~81.0%		81.1%	
		Yes, ~~integrated~~ Medical/Pharmacy		Yes, integrated	
		~~$6,500 integrated~~ N/A		$4,500 integrated	
		~~$12,000 integrated~~ N/A		$9,000 integrated	
		~~N/A~~$6,000 / ~~$500~~ / $0		N/A	
		~~N/A~~$12,000 / ~~$1000~~ / $0		N/A	
		$6,500		$6,500	
		$13,000		$13,000	
		N/A		$4,500	
		N/A		$4,500	
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 to treat an injury, illness, or condition	$70	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	$70	After 1st three non-preventive visits	40%	X
	Specialist visit	$90	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$40		40%	X
	X-rays and Diagnostic Imaging	~~0%~~100%	X	40%	X
	Imaging (CT/PET scans, MRIs)	~~0%~~100%	X	40%	X
Drugs to treat illness or condition	Tier 1	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
	Tier 2	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
	Tier 3	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
	Tier 4	~~0%~~100% up to $500 per script after pharmacy deductible	~~X~~Pharmacy Deductible	40%	X
Outpatient services	Surgery facility fee (e.g., ASC)	~~0%~~100%	X	40%	X
	Physician/surgeon fees	~~0%~~100%	X	40%	X
	Outpatient visit	~~0%~~100%	X	40%	X
Emergency services	Emergency room facility fee (waived if admitted)	~~0%~~100%	X	40%	X
	Emergency room physician fee (waived if admitted)	~~0%~~100%	X	40%	X
	Emergency medical transportation	~~0%~~100%	X	40%	X
Urgent care	Urgent care	$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	~~0%~~100%	X	40%	X
	Physician/surgeon fee	~~0%~~100%	X	40%	X
Mental health, behavioral health, or substance abuse treatment	Mental/Behavioral health outpatient office visits	$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services	$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	~~0%~~100%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee	~~0%~~100%	X	40%	X
	Substance Use disorder outpatient office visits	$70	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	$70	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	~~0%~~100%	X	40%	X
	Substance use disorder inpatient physician/surgeon fee	~~0%~~100%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services — Hospital	~~0%~~100%	X	40%	X
	Delivery and all inpatient services — Professional	~~0%~~100%	X	40%	X
Rehabilitative services	Home health care	~~0%~~100%	X	40%	X
	Outpatient Rehabilitation services	$70		40%	X
	Outpatient Habilitation services	$70		40%	X
Skilled nursing facility	Skilled nursing care	~~0%~~100%	X	40%	X
Durable medical equipment	Durable medical equipment	~~0%~~100%	X	40%	X
Hospice service	Hospice service	No charge		0%	X
Child eye exam	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

See endnotes.

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

	Catastrophic Plan
[redacted]	
[redacted]	Yes, integrated
[redacted]	$6,850 integrated
[redacted]	$13,700 integrated
[redacted]	N/A
[redacted]	N/A
[redacted]	$6,850
[redacted]	$13,700
[redacted]	N/A
[redacted]	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
[redacted]	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
[redacted]	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
[redacted]	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
[redacted]	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
[redacted]	Emergency room facility fee (waived if admitted)		0%	X
	Emergency room physician fee (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
[redacted]	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
[redacted]	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)		0%	X
	Mental/Behavioral health inpatient physician/surgeon fee		0%	X
	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)		0%	X
	Substance use disorder inpatient physician/surgeon fee		0%	X
[redacted]	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
[redacted]	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		0%	X
[redacted]	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	X
[redacted]	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered	
[redacted]	Amalgam Fill - 1 Surface		Not Covered	
[redacted]	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown		Not Covered	
[redacted]	Medically necessary orthodontics		Not Covered	

See endnotes.

Endnotes to 2016 Standard Benefit Plan Designs

Notes:

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the carrier.
2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For ~~all~~ plans ~~including~~ except HDHPs linked to HSA plans, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
5) For HDHPs linked to HSAs, in other than self-only coverage, ~~each individual in the family must meet the individual minimum deductible amount established by the Internal Revenue Service for the applicable Plan Year.~~ an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2600 for Plan Year 2016. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.
7) For the Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
8) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month per state law.
9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10) For drugs to treat an illness or condition, the copay or co-insurance applies to ~~the~~ an up to 30-day prescription supply. ~~For example, if the prescription is for a month's supply, one co-pay or co-insurance can be collected. If the prescription is written for a 90 day supply, a single cost-share amount applies~~. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost-share.

11) As applicable, for the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental Standard Benefit Plan 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 non-preventive child dental benefits.
12) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
13) Mental Health/Substance Use Disorder Outpatient Items and Services include post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.
14) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
15) Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate (28 CCR § 1300.51(l)(1)).
16) The Other Practitioner category includes Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors and other practitioners included in 28 CCR § 1300.67(a)(1).
17) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
18) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
19) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.

3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >$600.

20) ~~If a drug would otherwise qualify for placement on tier 4 and at least 3 treatment options are available for that particular condition as determined by either a plan's pharmaceutical and therapeutics (P&T) committee or indicated by the Food and Drug Administration (FDA) or according to applicable treatment guidelines for that condition, one drug used to treat that condition must be placed on either tier 1, 2 or 3.~~ Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs.

21) ~~All drugs covered in tier 4 must be expressly listed in the plan's formulary. All drugs placed in tiers 1 through 3 to treat the following conditions must be expressly listed in the plan's formulary: HIV/AIDs, hepatitis C, rheumatoid arthritis, multiple sclerosis, systemic lupus erythematosus.~~ Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.

~~22) A plan's formulary must include a statement that other drugs that are covered may not be listed on the formulary for tiers 1-3.~~

~~23~~22) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.

23) For 2016, a carrier may offer a plan with two in-network facility tiers if the lowest-cost tier network (Tier 1), complies with the cost-sharing requirements in the standard benefit plan design, meets state network adequacy and timeliness standards as applied by the applicable regulator and the carrier demonstrates that the two in-network facility tiers are in the best interest of the consumer as determined by Covered California on a case-by-case basis, based on premium stability, price, quality, choice and value. For non-Qualified Health Plans, the applicable regulator will review.

COVERED CALIFORNIA™

2016 Dental Standard Benefit Plan Designs

Date: ~~April 16~~May 21, 2015

Summary of Benefits and Coverage

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

	~~Standalone~~ Children's Dental Plan	~~Standalone~~ Children's Dental Plan
	Pediatric Dental EHB Copay 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™

2016 Dental Standard Benefit Plan Designs

Date: ~~April 16~~May 21, 2015

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 1367.50 (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™

2016 Dental Standard Benefit Plan Designs

Date: ~~April 16~~May 21, 2015

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 m... amount ... 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.
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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)

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