May 27, 2015

ADVANCE NOTICE OF INTENT TO FILE 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 proposes a re-adoption of the 2016 Standard Benefit Plan Designs which must be used by Qualified Health Plans that are certified in the Individual and SHOP Exchanges for Plan Year 2016 to be offered through Covered California. The proposed re-adoption offers a few changes from the regulation package adopting Section 6432 approved by OAL on February 19, 2015. 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 OAL's posting this Advance Notice on its website.

Response to public comments is strictly at the Exchange's discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange
Attn: Andrea Rosen
1601 Exposition Blvd.
Sacramento, CA 95815
Andrea.Rosen@covered.ca.gov

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814
staff@oal.ca.gov

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 date of OAL approval, unless the Exchange either repeals the regulations or makes them permanent through a certification of compliance pursuant to section 11346.1(e) within that two year period. Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. There will be a 45-day comment period within the two year certification period following the effective date of the emergency regulations.

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 Andrea Rosen at (916) 228-8343.

FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange finds 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.

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(e)

INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW

Documents to be incorporated by reference:

2016 Standard Benefit Plan Designs dated May 21, 2015 as amended on January 29, 2015 will be incorporated by reference in the proposed regulations.

Summary of Existing Laws

Under the federal Patient Protection and Affordable Care Act (PPACA), each state was required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange within state government. (Gov. Code § 100500 et seq.) The Exchange has the authority to standardize products to be offered through the Exchange. (Gov. Code § 100504 (c)). The Exchange shall establish and use a competitive process to select participating carriers. (Gov. Code §100505). The Exchange has exercised its authority to establish and require Qualified Health Plans to use the 2016 Standard Benefit Plan Designs for the 2016 Plan Year in order to make a side by side comparison of competing plans easier for Covered California enrollees. Using standard benefit plan designs will make it easier for enrollees to make an informed choice and choose the right plan for themselves and their families. The Exchange standard benefit plan designs must also be offered by non-Exchange issuers selling off-Exchange plans.

The proposed regulations amend the Exchange's standard benefit plan designs for Plan Year 2016 which were initially approved by OAL on February 19, 2015 and a subsequent re-adoption with minor changes was approved on March 18, 2015. Specifically, the proposed changes to these regulations will:

- For individual Platinum, Gold, Silver and Silver 73 plans and for SHOP silver plans, a cap of up to $250 per 30 day script is established for Tier 4 drugs.
- For SHOP Silver plans, the actuarial values were corrected, the individual plan pharmacy deductible was reduced from $500 to $250 per year, the family plan pharmacy deductible was reduced from $1000 to $500 per year and a per 30 day script cap was established for Tier 4 drugs.
- For the SHOP Silver Health Savings Account plan, the Revenue-Procedure 2015-30 amount for an individual's minimum deductible in a family plan was set.
- For the Silver cost-sharing reduction plans, 94 and 87, a cap of up to $150 per 30 day script Tier 4 drugs was set.
- For the Bronze plan, the actuarial value was adjusted, the integrated deductible was replaced by separate medical and pharmacy deductibles, a cap of up to $500 per 30 day script for all drug tiers was set and the co-insurance amounts up to the deductible were clarified.
- The proposed regulations includes amendments to the Endnotes that reflect the above changes to the benefit plan designs.
- The amendments also make minor clarification in the Endnotes that clarify that a recent federal rule regarding publication of all drugs, regardless of tier placement, must be listed in a plan's formulary to increase consumer transparency.
- Revised Endnote 20 which requires the placement of a qualifying Tier 4 drug on another Tier if at least 3 drugs in that class are available to increase clarity.
- The proposed regulations clarify that a plan may offer two in-network facility tiers and the requirements for these plans are established.

The proposed regulations will provide the health insurance issuers who seek to offer Qualified Health Plans for the Plan year 2016 with greater clarity regarding how the 2016 standard benefit plan designs that are required as a condition of certification and re-certification in the individual and SHOP Exchanges must be administered. In addition, the proposed changes to these regulations will guide regulators who approve insurance policy forms and evidence of coverage documents for off-exchange plans who are required by law to offer plans identical to on-exchange plans.

After an evaluation of current regulations, specifically 10 CCR 6460, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. These regulations comply with applicable federal rules requiring the use of the federal actuarial value calculator, and the 2016 Notice of Benefit and Payment Parameters at 45 CFR 153, 155 and 156, in particular, the federal requirements for publishing an up-to-date, accurate and complete list of covered drugs on plan formularies.

JUSTIFICATION FOR DUPLICATION

These proposed regulations were developed with significant stakeholder input, including health issuers and consumer representatives and do not duplicate Section 6460 but instead replace them for the 2016 Plan Year. While there are some similarities between 2015 and 2016 Standard Benefit Plan Designs, and they do both govern the enrollee's cost-sharing obligations, the proposed regulations provide greater specificity and details making for greater transparency for 2016 enrollees and the health insurance issuers who are administering these benefit plans. .

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 Section 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 AND TO FEDERAL FUNDING

The proposal results in some additional costs, mostly to enforce and ensure consistent administration, to the California Health Benefit Exchange, which is funded by participation fees paid by QHP health issuers to the Exchange. Additional savings in federal funding will be realized since no federal funds will be used to adopt and enforce the 2016 Standard Benefit Plan designs.

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
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%	
Need immediate attention	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	
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 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		No charge		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%		$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.

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
Actuarial Value - AV Calculator	80.2%	~~81.0%~~81.1%
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	$6,200	$6,200
Family Out-of-pocket maximum	$12,400	$12,400
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		$35		$35	
	Other practitioner office visit		$35		$35	
	Specialist visit		$55		$55	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$35		$35	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
Drugs to treat illness or condition	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	
Outpatient services	Surgery facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%		$55	
	Outpatient visit		20%		20%	
Need immediate attention	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	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%		$55	
Mental health, behavioral health, or substance abuse needs	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	
Pregnancy	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	
Help recovering or other special health needs	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	
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		No charge		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%		$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.

2016 Standard Benefit Plan Designs
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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: 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		$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%	
Need immediate attention	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	
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 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		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
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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 - AV Calculator	~~71.7%~~ 71.6%	~~71.4%~~ 71.3%
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: 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		$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%	
Need immediate attention	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		$90		$90	
Hospital stay	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
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 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		No charge		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%		$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.

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 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: Self-only 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
		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		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.

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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 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	$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: 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	$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
	Delivery and all inpatient services – 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	No charge		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%		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.	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	72.8%
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	$1,900 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$3,800 / $500 / $0
Individual Out–of–pocket maximum	$5,450
Family Out-of-pocket maximum	$10,900
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		$40	
	Other practitioner office visit		$40	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	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
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	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	
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		$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
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		$40	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
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		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.

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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	~~61.2%~~61.9%	61.1%
Plan design includes a deductible?	Yes, ~~integrated~~ Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	~~$6,500 integrated~~ N/A	$4,500 integrated
Integrated Family deductible	~~$13,000 integrated~~ N/A	$9,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	~~N/A~~$6,000 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	~~N/A~~$12,000 / $1,000 / $0	N/A
Individual Out–of–pocket maximum	$6,500	$6,500
Family Out-of-pocket maximum	$13,000	$13,000
HSA plan: Self-only coverage deductible	N/A	$4,500
HSA family plan: Individual deductible	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
Need immediate attention	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		$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 needs	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
		Professional	~~0%~~100%	X	40%	X
Help recovering or other special health needs	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
	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		No charge		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%		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	
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 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 care	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		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
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 Orthodontics	Medically necessary orthodontics		0%	X

See endnotes.

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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%	
Need immediate attention	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	
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 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		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.

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.2%	~~81.0%~~81.1%
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	$6,200	$6,200
Family Out-of-pocket maximum	$12,400	$12,400
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		$35		$35	
	Other practitioner office visit		$35		$35	
	Specialist visit		$55		$55	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$35		$35	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
Drugs to treat illness or condition	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	
Outpatient services	Surgery facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%		$55	
	Outpatient visit		20%		20%	
Need immediate attention	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	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%		$55	
Mental health, behavioral health, or substance abuse needs	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	
Pregnancy	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	
Help recovering or other special health needs	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	
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		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.	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: 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		$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%	
Need immediate attention	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	
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 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		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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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	SHOP Silver Coinsurance Plan	SHOP Silver Copay Plan
Actuarial Value - AV Calculator	~~71.7%~~ 71.6%	~~71.4%~~ 71.3%
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: 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		$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%	
Need immediate attention	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		$90		$90	
Hospital stay	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
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 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		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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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: Self-only 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
		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		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 Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	93.8%	~~86.8%~~86.9%
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	$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: 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		$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		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 Plan 200%-250% FPL
Actuarial Value - AV Calculator	72.8%
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	$1,900 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$3,800 / $500 / $0
Individual Out–of–pocket maximum	$5,450
Family Out-of-pocket maximum	$10,900
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		$40	
	Other practitioner office visit		$40	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	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
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	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	
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		$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
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		$40	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
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		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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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	~~61.19%~~61.9%	61.1%
Plan design includes a deductible?	Yes, ~~integrated~~ Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	~~$6,500 integrated~~ N/A	$4,500 integrated
Integrated Family deductible	~~$13,000 integrated~~ N/A	$9,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	~~N/A~~$6,000 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	~~N/A~~$12,000 / $1000 / $0	N/A
Individual Out–of–pocket maximum	$6,500	$6,500
Family Out-of-pocket maximum	$13,000	$13,000
HSA plan: Self-only coverage deductible	N/A	$4,500
HSA family plan: Individual deductible	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
Need immediate attention	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	$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 needs	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
Help recovering or other special health needs	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
	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	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	

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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 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 care	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		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.

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 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™

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 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	Andrea Rosen	andrea.rosen@covered.ca	916-228-8343

DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400	NOTICE FILE NUMBER
2016 Standard Benefit Plan Designs	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: _____

_____

_____

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 State (sustainability) funds will be utilized if Federal funds are insufficient to cover costs in Fiscal Year (FY) 2014/15. State (sustainability) funds that may be utilized are not from the General Fund.

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 of Federal Funds (Grant) is $169,293 in FY2014/15. Requires no additional funding authority. This proposal has no impact on the General Fund. For details see Attachment.

FISCAL OFFICER SIGNATURE	DATE
	2/6/15

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
	2.6.15

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

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%	$ 3,506	$ 1,367	**$ 4,873**	$ 267	**$ 5,140**	1.0	$ 5,140
PMD Director @ 25%	$ 7,500	$ 2,925	**$ 10,425**	$ 667	**$ 11,092**	1.0	$ 11,092
Assoc. Gov. Program Analyst (AGPA) @ 50%	$ 10,106	$ 3,941	**$ 14,047**	$ 1,333	**$ 15,380**	2.0	$ 30,761
Total	$ 21,112	$ 8,233	**$ 29,345**	$ 2,267	**$ 31,612**	4.0	**$ 46,993**

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 $8,000, prorated based on the same parameters as salary.
4. Staffing level and associated classifications provided by program.

Contract Costs

Contract/Contractor	Amount
Ted von Glahn	$ 5,225
Bertko Acturial Associates, LLC	$ 2,325
Milliman, Inc.	$ 36,000
Tori Group	$ 78,750
Total	**$ 122,300**

Total Summary

Cost Category	Amount
Total PS & OE&E	$ 46,993
Total Contracts	$ 122,300
Total Cost	**$ 169,293**

Covered California
2015 Standard Benefit Design Rulemaking
PS Calculations Supporting Documentation

Personal Services -Salary

Classification	Salary Bottom	Salary Mid	Salary Top	Duration/Tenure (in months)	Time Allocation [2]	Salary Cost	Staffing Level	Total Salary Cost[1]
C.E.A. Level B		8,766		4.0	2 months @ 10%	$ 3,506	1.0	$ 3,506
PMD Director		15,000		2.0	4 months @ 25%	$ 7,500	1.0	$ 7,500
Assoc. Gov. Program Analyst (AGPA)	4,488	5,053	5,618	4.0	4 months @ 50%	$ 10,106	2.0	$ 20,212
							Total Salary Cost	**$ 31,218** [A]

[1] Salary calculations based on mid-step of classification.
[2] The (4) month measurement period is 02/01/14 - 05/31/2014

Personal Services -Benefits

Classification	Benefit Rate	Total Salary Cost	Benefit Amount	Staffing Level	Total Benefit Cost
C.E.A. Level B	39%	$ 3,506	$ 1,367	1.0	$ 1,367
PMD Director	39%	$ 7,500	$ 2,925	1.0	$ 2,925
Assoc. Gov. Program Analyst (AGPA)	39%	$ 10,106	$ 3,941	2.0	$ 7,882
				Total Benefit Cost	**$ 12,174** [B]

Operating Expenses & Equipment

Classification	Standard EO&E	Time Allocation [2]	OE&E Proration	Staffing Level	Total OE&E Cost
C.E.A. Level B	$ 8,000	2 months @ 10%	$ 267	1.0	$ 267
PMD Director	$ 8,000	4 months @ 25%	$ 667	1.0	$ 667
Assoc. Gov. Program Analyst (AGPA)	$ 8,000	4 months @ 50%	$ 1,333	2.0	$ 2,667
				Total OE&E cost	**$ 3,601** [C]

TOTAL PS & OE&E COST	**$ 46,993**	[A + B +C]