2016 Standard Benefit Plan Designs

May 21, 2015

Final OAL-approved

2016 Standard Benefit Plan Designs
10.0 EHB
Date: 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.

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Summary of Benefits and Coverage

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

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.2%	81.0%
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	
	Delivery and all inpatient services – 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.

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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.

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Summary of Benefits and Coverage

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

	SHOP Silver Coinsurance Plan	SHOP Silver Copay Plan
Actuarial Value - AV Calculator	71.6%	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 / $250 / $0	$1,500 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$3,000 / $500 / $0	$3,000 / $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.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	SHOP Silver HSA Plan
Actuarial Value - AV Calculator	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	$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%
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		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%	

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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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Summary of Benefits and Coverage

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

	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	61.9%	61.1%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$4,500 integrated
Integrated Family deductible	N/A	$9,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,000 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$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		100%	X	40%	X
	Imaging (CT/PET scans, MRIs)		100%	X	40%	X
Drugs to treat illness or condition	Tier 1		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 2		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 3		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 4		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
Outpatient services	Surgery facility fee (e.g., ASC)		100%	X	40%	X
	Physician/surgeon fees		100%	X	40%	X
	Outpatient visit		100%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		100%	X	40%	X
	Emergency room physician fee (waived if admitted)		100%	X	40%	X
	Emergency medical transportation		100%	X	40%	X
	Urgent care		$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		100%	X	40%	X
	Physician/surgeon fee		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)		100%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee		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)		100%	X	40%	X
	Substance use disorder inpatient physician/surgeon fee		100%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care		100%	X	40%	X
	Outpatient Rehabilitation services		$70		40%	X
	Outpatient Habilitation services		$70		40%	X
	Skilled nursing care		100%	X	40%	X
	Durable medical equipment		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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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$6,850 integrated
Integrated Family deductible	$13,700 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$6,850
Family Out-of-pocket maximum	$13,700
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
Outpatient services	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
Need immediate 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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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		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad				Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted				Not Covered	
	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

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

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.2%	81.0%
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	
	Delivery and all inpatient services – 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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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	71.6%	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 / $250 / $0	$1,500 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$3,000 / $500 / $0	$3,000 / $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
	Delivery and all inpatient services – 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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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	$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%
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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Summary of Benefits and Coverage

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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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	61.9%	61.1%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$4,500 integrated
Integrated Family deductible	N/A	$9,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,000 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$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		100%	X	40%	X
	Imaging (CT/PET scans, MRIs)		100%	X	40%	X
Drugs to treat illness or condition	Tier 1		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 2		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 3		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
	Tier 4		100% up to $500 per script after pharmacy deductible	Pharmacy Deductible	40%	X
Outpatient services	Surgery facility fee (e.g., ASC)		100%	X	40%	X
	Physician/surgeon fees		100%	X	40%	X
	Outpatient visit		100%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)		100%	X	40%	X
	Emergency room physician fee (waived if admitted)		100%	X	40%	X
	Emergency medical transportation		100%	X	40%	X
	Urgent care		$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		100%	X	40%	X
	Physician/surgeon fee		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)		100%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee		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)		100%	X	40%	X
	Substance use disorder inpatient physician/surgeon fee		100%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care		100%	X	40%	X
	Outpatient Rehabilitation services		$70		40%	X
	Outpatient Habilitation services		$70		40%	X
	Skilled nursing care		100%	X	40%	X
	Durable medical equipment		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	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$6,850 integrated
Integrated Family deductible	$13,700 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$6,850
Family Out-of-pocket maximum	$13,700
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventive visits
	Other practitioner office visit		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Tier 1		0%	X
	Tier 2		0%	X
	Tier 3		0%	X
	Tier 4		0%	X
Outpatient services	Surgery facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
Need immediate 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 plans 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, 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 an up to 30-day prescription supply. 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) 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) 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 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: May 21, 2015

Summary of Benefits and Coverage

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

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

Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Diagnostic & Preventive	Oral Exam	$0		0%	
	Preventive - Cleaning	$0		0%	
	Preventive - X-ray	$0		0%	
	Sealants per Tooth	$0		0%	
	Topical Fluoride Application	$0		0%	
	Space Maintainers - Fixed	$0		0%	
Basic Services	Amalgam Fill - One Surface	$25		20%	x
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	$300		50%	x
	Gingivectomy per Quad	$150			
	Extraction- Single Tooth Exposed Root or Erupted	$65			
	Extraction - Complete Bony	$160			
	Crown - Porcelain with Metal	$300			
Orthodontia	Medically Necessary Orthodontia	$350		50%	x

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

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
2) Cost sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

5) Each adult is responsible for an individual deductible.
6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

COVERED CALIFORNIA™

2016 Dental Standard Benefit Plan Designs

Date: 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: 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.