

**California Health Benefit Exchange
Standardized Benefit Plan Designs
Summary of Benefits and Coverage**

COST SHARING AMOUNTS
DESCRIBE THE ENROLLEE'S OUT
OF POCKET COSTS

		Platinum-Coinsurance Plan	Platinum-Copay Plan	Gold-Coinsurance Plan	Gold-Copay Plan	Silver-Coinsurance Plan
11/9/2012						
Estimated Actuarial Value		89%	88%	81%	80%	71%
Overall deductible		\$0	N/A	\$500	N/A	\$1,000
Other deductibles for specific services						
Facility-related Services			\$0		\$500	
Brand Drugs		\$0	\$0	\$100	\$100	\$250
Dental		TBD	TBD	TBD	TBD	TBD
Out-of-pocket limit on expenses		\$1,250	\$1,250	\$2,500	\$2,500	\$5,500
Common Medical Event	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (<i>deductible waived for first 2 visits except Non-Participating Providers or HSA plans--see footnote</i>)	\$20	\$20	\$30	\$30	\$40
	Specialist visit	\$20	\$20	\$30	\$30	\$40
	Other practitioner office visit	10%	\$20	20%	\$30	30%
	Preventive care/ screening/	No cost share	No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)	10%	\$20	20%	\$30	30%
	Imaging (CT/PET scans, MRIs)	10%	10%	20%	20%	30%
Drugs to treat illness or condition	Generic drugs	\$5	\$5	\$10	\$10	\$15
	Preferred brand drugs	\$15	\$15	\$20	\$20	\$25
	Non-preferred brand drugs	\$25	\$25	\$35	\$35	\$40
	Specialty drugs	10%	10%	20%	20%	30%
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10%	10%	20%	20%	30%
	Physician/surgeon fees	10%	\$100	20%	\$150	30%
Need immediate attention	Emergency room services (waived if admitted)	\$150	\$150	\$200	\$200	\$250
	Emergency medical transportation	10%	\$150	20%	\$150	30%
	Urgent care	\$40	\$40	\$50	\$50	\$55
Hospital stay	Facility fee (e.g., hospital room)	10%	10%	20%	20%	30%
	Physician/surgeon fee	10%	\$200	20%	\$250	30%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20	\$20	\$30	\$30	\$40
	Mental/Behavioral health inpatient services	10%	10%	20%	20%	30%
	Substance use disorder outpatient services	\$20	\$20	\$30	\$30	\$40
	Substance use disorder inpatient services	10%	10%	20%	20%	30%
Pregnancy	Prenatal and postnatal care	\$20	\$20	\$30	\$30	\$30
	Delivery and all inpatient services	10%	\$200	20%	\$250	30%
Help recovering or other special health needs	Professional Hospital	10%	10%	20%	20%	30%
	Home health care	10%	\$20	20%	\$30	30%
	Rehabilitation services	10%	\$20	20%	\$30	30%
	Habilitation services	10%	\$20	20%	\$30	30%
	Skilled nursing care	10%	10%	20%	20%	30%
	Durable medical equipment	10%	10%	20%	20%	30%
	Hospice service	No cost share	No cost share	No cost share	No cost share	No cost share
Child needs dental or eye care	Eye exam (<i>deductible waived</i>)	0%	0%	0%	0%	0%
	Glasses	\$20	\$20	\$30	\$30	\$40
	Dental check-up - Preventive and Diagnostic Services (<i>deductible waived</i>)	0%	0%	0%	0%	0%
	Dental Basic Services	TBD	TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services	TBD	TBD	TBD	TBD	TBD

- Notes:**
- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
 - 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
 - 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
 - 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
 - 5) For all plans other than Catastrophic, deductible is waived for the first 2 office visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
 - 6) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
 - 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
 - 8) Glasses coverage reflects a \$100 allowance for frames and a limit of one pair per year
 - 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
 - 10) Orthodontia coverage is limited to medically necessary services

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COST SHARING AMOUNTS
DESCRIBE THE ENROLLEE'S OUT
OF POCKET COSTS

		Silver Coins Plan-100%- 150% FPL	Silver Coins Plan-150%- 200% FPL	Silver Coins Plan-200%- 250% FPL	Silver-Copay Plan	Silver Copay Plan 100%- 150% FPL
11/9/2012						
Estimated Actuarial Value		94%	87%	79%	68%	93%
Overall deductible		\$0	\$250	\$1,000	N/A	N/A
Other deductibles for specific services						
Facility-related Services					\$1,000	\$0
Brand Drugs		\$0	\$0	\$250	\$250	\$0
Dental		TBD	TBD	TBD	TBD	TBD
Out-of-pocket limit on expenses		\$1,833	\$1,833	\$2,750	\$5,500	\$1,833
Common Medical Event	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (<i>deductible waived for first 2 visits except Non-Participating Providers or HSA plans--see footnote</i>)	\$3	\$10	\$40	\$40	\$3
	Specialist visit	\$3	\$10	\$40	\$40	\$3
	Other practitioner office visit	5%	10%	30%	\$40	\$3
	Preventive care/ screening/	No cost share	No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)	5%	10%	30%	\$40	\$3
	Imaging (CT/PET scans, MRIs)	5%	10%	30%	30%	5%
Drugs to treat illness or condition	Generic drugs	\$3	\$10	\$15	\$15	\$3
	Preferred brand drugs	\$5	\$15	\$25	\$25	\$5
	Non-preferred brand drugs	\$8	\$20	\$40	\$40	\$8
	Specialty drugs	5%	10%	30%	30%	5%
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5%	10%	30%	30%	5%
	Physician/surgeon fees	5%	10%	30%	\$200	\$25
Need immediate attention	Emergency room services (waived if admitted)	\$25	\$100	\$250	\$250	\$25
	Emergency medical transportation	5%	10%	30%	\$150	\$25
	Urgent care	\$5	\$15	\$55	\$55	\$5
Hospital stay	Facility fee (e.g., hospital room)	5%	10%	30%	30%	5%
	Physician/surgeon fee	5%	10%	30%	\$350	\$40
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$3	\$10	\$40	\$40	\$3
	Mental/Behavioral health inpatient services	5%	10%	30%	30%	5%
	Substance use disorder outpatient services	\$3	\$10	\$40	\$40	\$3
	Substance use disorder inpatient services	5%	10%	30%	30%	5%
Pregnancy	Prenatal and postnatal care	\$3	\$10	\$30	\$30	\$3
	Delivery and all inpatient services	5%	10%	30%	\$350	\$40
Help recovering or other special health needs	Home health care	5%	10%	30%	\$40	\$3
	Rehabilitation services	5%	10%	30%	\$40	\$3
	Habilitation services	5%	10%	30%	\$40	\$3
	Skilled nursing care	5%	10%	30%	30%	5%
	Durable medical equipment	5%	10%	30%	30%	5%
	Hospice service	No cost share	No cost share	No cost share	No cost share	No cost share
	Eye exam (<i>deductible waived</i>)	0%	0%	0%	0%	0%
Child needs dental or eye care	Glasses	\$3	\$10	\$40	\$40	\$3
	Dental check-up - Preventive and Diagnostic Services (<i>deductible waived</i>)	0%	0%	0%	0%	0%
	Dental Basic Services	TBD	TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services	TBD	TBD	TBD	TBD	TBD

Notes:

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- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 5) For all plans other than Catastrophic, deductible is waived for the first 2 office visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
- 6) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 8) Glasses coverage reflects a \$100 allowance for frames and a limit of one pair per year
- 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
- 10) Orthodontia coverage is limited to medically necessary services

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		Silver Copay Plan 150%-200% FPL	Silver Copay Plan 200%-250% FPL	Silver-HSA Plan	Bronze-Coinsurance Plan	Bronze-Copay Plan
11/9/2012						
Estimated Actuarial Value		87%	79%	70%	64%	63%
Overall deductible		N/A	N/A	\$1,300	\$2,000	N/A
Other deductibles for specific services						
Facility-related Services		\$250	\$1,000			\$2,000
Brand Drugs		\$0	\$250	\$0	\$750	\$500
Dental		TBD	TBD	TBD	TBD	TBD
Out-of-pocket limit on expenses		\$1,833	\$2,750	\$5,000	\$6,350	\$6,350
Common Medical Event	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (<i>deductible waived for first 2 visits except Non-Participating Providers or HSA plans--see footnote</i>)	\$10	\$40	20%	\$60	\$70
	Specialist visit	\$10	\$40	20%	\$60	\$70
	Other practitioner office visit	\$10	\$40	20%	40%	\$70
	Preventive care/ screening/	No cost share	No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)	\$10	\$40	20%	40%	\$70
	Imaging (CT/PET scans, MRIs)	10%	30%	20%	40%	40%
Drugs to treat illness or condition	Generic drugs	\$10	\$15	20%	\$20	\$20
	Preferred brand drugs	\$15	\$25	20%	\$45	\$45
	Non-preferred brand drugs	\$20	\$40	20%	\$60	\$60
	Specialty drugs	10%	30%	20%	40%	40%
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10%	30%	20%	40%	40%
	Physician/surgeon fees	\$25	\$200	20%	40%	\$500
Need immediate attention	Emergency room services (waived if admitted)	\$100	\$250	20%	\$250	\$250
	Emergency medical transportation	\$50	\$150	20%	40%	\$300
	Urgent care	\$15	\$55	20%	\$75	\$75
Hospital stay	Facility fee (e.g., hospital room)	10%	30%	20%	40%	40%
	Physician/surgeon fee	\$50	\$350	20%	40%	\$750
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$10	\$40	20%	\$60	\$70
	Mental/Behavioral health inpatient services	10%	30%	20%	40%	40%
	Substance use disorder outpatient services	\$10	\$40	20%	\$60	\$70
	Substance use disorder inpatient services	10%	30%	20%	40%	40%
Pregnancy	Prenatal and postnatal care	\$10	\$30	20%	\$30	\$30
	Delivery and all inpatient services	\$50	\$350	20%	40%	\$750
Help recovering or other special health needs	Home health care	10%	30%	20%	40%	40%
	Rehabilitation services	\$10	\$40	20%	40%	\$70
	Habilitation services	\$10	\$40	20%	40%	\$70
	Skilled nursing care	10%	30%	20%	40%	40%
	Durable medical equipment	10%	30%	20%	40%	40%
	Hospice service	No cost share	No cost share	No cost share	No cost share	No cost share
	Eye exam (<i>deductible waived</i>)	0%	0%	20%	0%	0%
Child needs dental or eye care	Glasses	\$10	\$40	20%	\$60	\$60
	Dental check-up - Preventive and Diagnostic Services (<i>deductible waived</i>)	0%	0%	0%	0%	0%
	Dental Basic Services	TBD	TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services	TBD	TBD	TBD	TBD	TBD

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	Bronze-HSA Plan	Catastrophic Plan
11/9/2012		
Estimated Actuarial Value	61%	64%
Overall deductible	\$2,000	\$6,350
Other deductibles for specific services		
Facility-related Services		
Brand Drugs	\$0	\$0
Dental	TBD	TBD
Out-of-pocket limit on expenses	\$6,350	\$6,350

Common Medical Event	Service Type	Member Cost Share	Member Cost Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (<i>deductible waived for first 2 visits except Non-Participating Providers or HSA plans--see footnote</i>)	30%	0%
	Specialist visit	30%	0%
	Other practitioner office visit	30%	0%
	Preventive care/ screening/	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)	30%	0%
	Imaging (CT/PET scans, MRIs)	30%	0%
Drugs to treat illness or condition	Generic drugs	30%	0%
	Preferred brand drugs	30%	0%
	Non-preferred brand drugs	30%	0%
	Specialty drugs	30%	0%
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30%	0%
	Physician/surgeon fees	30%	0%
Need immediate attention	Emergency room services (waived if admitted)	30%	0%
	Emergency medical transportation	30%	0%
	Urgent care	30%	0%
Hospital stay	Facility fee (e.g., hospital room)	30%	0%
	Physician/surgeon fee	30%	0%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30%	0%
	Mental/Behavioral health inpatient services	30%	0%
	Substance use disorder outpatient services	30%	0%
	Substance use disorder inpatient services	30%	0%
Pregnancy	Prenatal and postnatal care	30%	0%
	Delivery and all inpatient services	Professional Hospital	30%
Help recovering or other special health needs	Home health care	30%	0%
	Rehabilitation services	30%	0%
	Habilitation services	30%	0%
	Skilled nursing care	30%	0%
	Durable medical equipment	30%	0%
	Hospice service	No cost share	No cost share
Child needs dental or eye care	Eye exam (<i>deductible waived</i>)	30%	0%
	Glasses	30%	0%
	Dental check-up - Preventive and Diagnostic Services (<i>deductible waived</i>)	0%	0%
	Dental Basic Services	TBD	TBD
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- 10) Orthodontia coverage is limited to medically necessary services