

**State of California  
Office of Administrative Law**

**In re:**  
**California Health Benefit Exchange**

**Regulatory Action:**

**Title 10, California Code of Regulations**

**Adopt sections: 6458**

**Amend sections:**

**Repeal sections:**

**NOTICE OF APPROVAL OF EMERGENCY  
REGULATORY ACTION**

**Government Code Sections 11346.1 and  
11349.6**

**OAL File No. 2014-0606-01 EE**

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In this emergency readopt, HBEX proposes to adopt the 2014 Standard Benefit Plan Designs, which standardizes the way health insurance issuers design their health plans.

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

This emergency regulatory action is effective on 6/16/2014 and will expire on . The Certificate of Compliance for this action is due no later than 9/15/2014.

**Date: 6/16/2014**

  
\_\_\_\_\_  
Thanh Huynh  
Senior Attorney

**For: DEBRA M. CORNEZ  
Director**

**Original: Peter Lee  
Copy: Brandon Ross**

## NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER <b>Z-</b>	REGULATORY ACTION NUMBER	EMERGENCY NUMBER <b>2014-0606-01EE</b>
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For use by Office of Administrative Law (OAL) only

2014 JUN -6 PM 1:34

OFFICE OF  
ADMINISTRATIVE LAWENDORSED FILED  
IN THE OFFICE OF

2014 JUN 16 PM 1:58

  
 DESHA BOWEN  
 SECRETARY OF STATE

NOTICE

REGULATIONS

 AGENCY WITH RULEMAKING AUTHORITY  
 California Health Benefit Exchange

AGENCY FILE NUMBER (if any)

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

1. SUBJECT OF NOTICE		TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
3. NOTICE TYPE <input type="checkbox"/> Notice re Proposed Regulatory Action <input type="checkbox"/> Other		4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY	ACTION ON PROPOSED NOTICE <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn		NOTICE REGISTER NUMBER	PUBLICATION DATE

**B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)**

1a. SUBJECT OF REGULATION(S) 2014 Standard Benefit Design	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S) 2013-0910-03 E; 2014-0307-01EE
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2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT 6458
	AMEND
	REPEAL
TITLE(S) 10	

3. TYPE OF FILING

<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346) <input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §511349.3, 11349.4) <input type="checkbox"/> Emergency (Gov. Code, §11346.1(b))	<input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §511346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute. <input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input checked="" type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h)) <input type="checkbox"/> File & Print <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100) <input type="checkbox"/> Print Only
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4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

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

<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input checked="" type="checkbox"/> Effective on filing with Secretary of State	<input type="checkbox"/> \$100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify) _____
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6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY


<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660) <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Fair Political Practices Commission	<input type="checkbox"/> State Fire Marshal
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7. CONTACT PERSON

Brandon Ross	TELEPHONE NUMBER 916-228-8281	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) brandon.ross@covered.ca.gov
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8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE

  
 TYPED NAME AND TITLE OF SIGNATORY  
 Kathleen Keeshen, General Counsel

DATE

6/6/2014

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

JUN 16 2014

Office of Administrative Law

**Readopt Section 6458 to read:**

**Section 6458: 2014 Standard Benefit Plan Designs**

- (a) For plan year and calendar year 2014, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2014 Standard Benefit Plan Designs – FINAL, dated July 18, 2013, which is incorporated by reference.

**Authority:** Government Code Section 100504

**Reference:** Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

**Covered California**  
**2014 Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Platinum Coinsurance Plan		Platinum Copay Plan	
7/18/2013					
Overall deductible		\$0		\$0	
Other deductibles for specific services					
Medical		\$0		\$0	
Brand Drugs		\$0		\$0	
Dental		See Dental Design Below		See Dental Design Below	
Out-of-pocket limit on expenses		\$4,000		\$4,000	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20		\$20	
	Specialist visit	\$40		\$40	
	Other practitioner office visit	\$20		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
Outpatient surgery	Specialty drugs	10%		10%	
	Facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%			
	Emergency room services (waived if admitted)	\$150		\$150	
Need immediate attention	Emergency medical transportation	\$150		\$150	
	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g., hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20		\$20	
	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days	
	Substance use disorder outpatient services	\$20		\$20	
	Substance use disorder inpatient services	10%		\$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	10%		\$250 per day up to 5 days	
	Home health care	10%		\$20	
	Rehabilitation services	\$20		\$20	
Help recovering or other special health needs	Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Dental Design Below		See Dental Design Below	
	Dental Basic Services				
	Dental Restorative and Orthodontia Services				

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.

5) "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.

**Covered California**  
**2014 Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

7/18/2013

		Individual Only		Individual Only	
		Silver Coinsurance Plan		Silver Copay Plan	
Overall deductible		N/A		N/A	
Other deductibles for specific services					
Medical		\$2,000		\$2,000	
Brand Drugs		\$250		\$250	
Dental		See Dental Design Below		See Dental Design Below	
Out-of-pocket limit on expenses		\$6,350		\$6,350	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$45		\$45	
	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$45		\$45	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Drugs to treat illness or condition	Generic drugs	\$19		\$19	
	Preferred brand drugs	\$50	X	\$50	X
	Non-preferred brand drugs	\$70	X	\$70	X
	Specialty drugs	20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Emergency room services (waived if admitted)	\$250	X	\$250	X
	Emergency medical transportation	\$250	X	\$250	X
Need immediate attention	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g., hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45		\$45	
	Mental/Behavioral health inpatient services	20%	X	20%	X
	Substance use disorder outpatient services	\$45		\$45	
	Substance use disorder inpatient services	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	20%	X	20%	X
	Home health care	20%		\$45	
	Rehabilitation services	\$45		\$45	
Help recovering or other special health needs	Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic				
	Dental Basic Services	See Dental Design Below		See Dental Design Below	
	Dental Restorative and Orthodontia Services				

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
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**Covered California**  
**2014 Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

7/18/2013

		SHOP Only	
		Silver HSA Plan	
Overall deductible		\$1,500 Integrated Med/Rx	
Other deductibles for specific services			
Medical		N/A	
Brand Drugs		N/A	
Dental		See Dental Design Below	
Out-of-pocket limit on expenses		\$6,350	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	20%	X
	Specialist visit	20%	X
	Other practitioner office visit	20%	X
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	20%	X
	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
Drugs to treat illness or condition	Generic drugs	20%	X
	Preferred brand drugs	20%	X
	Non-preferred brand drugs	20%	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees	20%	X
	Emergency room services (waived if admitted)	20%	X
	Emergency medical transportation	20%	X
Need immediate attention	Urgent care	20%	X
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20%	X
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	20%	X
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services	20%	X
	Professional	20%	X
	Home health care	20%	X
Help recovering or other special health needs	Rehabilitation services	20%	X
	Habilitation services	20%	X
	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
Child needs dental or eye care	Hospice service	No cost share	X
	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic	See Dental Design Below	
	Dental Basic Services		
	Dental Restorative and Orthodontia Services		

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 5) "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.

**Covered California**  
**2014 Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

7/18/2013

Individual Only

Silver Coinsurance Plan  
 200%-250% FPL

Overall deductible		N/A	
Other deductibles for specific services			
Medical		\$1,500	
Brand Drugs		\$250	
Dental		See Dental Design Below	
Out-of-pocket limit on expenses		\$5,200	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40	
	Specialist visit	\$50	
	Other practitioner office visit	\$40	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	\$40	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	20%	X
Drugs to treat illness or condition	Generic drugs	\$19	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
Need immediate attention	Urgent care	\$80	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee	20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services	20%	X
	Professional	20%	
	Home health care	20%	
Help recovering or other special health needs	Rehabilitation services	\$40	
	Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child needs dental or eye care	Hospice service	No cost share	
	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic		
	Dental Basic Services	See Dental Design Below	
	Dental Restorative and Orthodontia Services		

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 5) "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.

**Covered California**  
**2014 Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

7/18/2013

		Individual Only	
		Silver Copay Plan 200%-250% FPL	
Overall deductible		N/A	
Other deductibles for specific services			
Medical		\$1,500	
Brand Drugs		\$250	
Dental		See Dental Design Below	
Out-of-pocket limit on expenses		\$5,200	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40	
	Specialist visit	\$50	
	Other practitioner office visit	\$40	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	\$40	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Generic drugs	\$19	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
Need immediate attention	Urgent care	\$80	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee		
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services		
	Hospital Professional	20%	X
	Home health care	\$40	
Help recovering or other special health needs	Rehabilitation services	\$40	
	Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child needs dental or eye care	Hospice service	No cost share	
	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic		
	Dental Basic Services	See Dental Design Below	
	Dental Restorative and Orthodontia Services		

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 5) "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.



**Covered California**  
**2014 Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

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

7/18/2013

		Catastrophic Plan	
<b>Overall deductible</b>		\$6,350 integrated Med/Rx	
<b>Other deductibles for specific services</b>			
Medical		N/A	
Brand Drugs		N/A	
Dental		See Dental Design Below	
<b>Out-of-pocket limit on expenses</b>		\$6,350	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
<b>Visit to a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	0%	After 1st 3 non-preventive visits
	Specialist visit	0%	X
	Other practitioner office visit	0%	X
	Preventive care/ screening/ immunization	No cost share	
<b>Tests</b>	Laboratory Tests	0%	X
	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
<b>Drugs to treat illness or condition</b>	Generic drugs	0%	X
	Preferred brand drugs	0%	X
	Non-preferred brand drugs	0%	X
	Specialty drugs	0%	X
<b>Outpatient surgery</b>	Facility fee (e.g., ASC)	0%	X
	Physician/surgeon fees	0%	X
	Emergency room services (waived if admitted)	0%	X
<b>Need immediate attention</b>	Emergency medical transportation	0%	X
	Urgent care	0%	After 1st 3 non-preventive visits
<b>Hospital stay</b>	Facility fee (e.g., hospital room)	0%	X
	Physician/surgeon fee	0%	X
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	0%	After 1st 3 non-preventive visits
	Mental/Behavioral health inpatient services	0%	X
	Substance use disorder outpatient services	0%	After 1st 3 non-preventive visits
	Substance use disorder inpatient services	0%	X
<b>Pregnancy</b>	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services	0%	X
	Home health care	0%	X
	Rehabilitation services	0%	X
<b>Help recovering or other special health needs</b>	Habilitation services	0%	X
	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	No cost share	X
<b>Child needs dental or eye care</b>	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic		
	Dental Basic Services	See Dental Design Below	
	Dental Restorative and Orthodontia Services		

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 5) "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.

**Covered California  
Standard Pediatric Dental Essential Health Benefits Plan Design  
For the 2014 Plan Year**

Procedure Categories	DPPO High	DPPO Low	DHMO High	DHMO Low
<b>Diagnostic &amp; Preventive (D&amp;P)</b> X-rays, Exams, Cleanings Sealants	Plan Pays: 100%	100%	Enrollee Pays: \$0	\$0
<b>Office Visit</b>	n/a	n/a	\$0	\$20
<b>Basic Services - Basic Restorative</b>	80%	50%	\$40 <sup>3</sup>	\$95 <sup>3</sup>
<b>Major Services - Crowns &amp; Casts, Prosthodontics, Endodontics, Periodontics, Oral Surgery</b>	50%	50%	\$365 <sup>4</sup>	\$365 <sup>4</sup>
<b>Orthodontics (Medically Necessary)</b>	Enrollee Pays: 50%	50%	\$1,000	\$1,000
<b>Deductible</b>	\$50 (not applied to D&P)	\$60 (applied to all services)	None	None
<b>Annual Maximum</b>	None	None	None	None
<b>OOP Maximum</b>	\$1,000	\$1,000	\$1,000	\$1,000
<b>Waiting Periods (Major &amp; Ortho)</b>	None	None	None	None
<b>Actuarial Value (AV)</b>	86%	72%	87%	72%

**Notes:**

1. Actuarial values are based on pediatric claims experience.
2. Orthodontics includes medically-necessary orthodontia only.
3. DHMO Basic Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.
4. DHMO Major Services copayments vary by procedure within this category. Using a statistically significant set of claims data, the plan's average co-pay charged for procedures in this category cannot exceed the stated amount.
5. When more than one child is covered by a pediatric dental plan or policy, the policy/plan deductibles and out of pocket maximum amounts are equal to 2 times the individual values, however each individual child is responsible only for the single deductible and out of pocket maximum in a plan year.
6. Dental Exclusive Provider Organization (DEPO) products must conform to the DHMO Benefit Plan Design.