

2018 DRAFT Dental Standard Benefit Plan Designs

Date: January 12, 2016

Summary of Benefits and Coverage Coinsurance Plan Copay Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business. Actuarial Value Belse Services In-Network In-Network Individual Deductible Se6 Se6 Se6 None Family Deductible (Two or more children) Individual Out of Pocket Maximum Syston Syrup Code 1357:50 (a)(3)(J)(4) and Insurance Code 10198.8(d) Proceedure Category Oral Exam Oral Exam Preventive Preventive Restorative Procedures Periodontics Oral Surgery Orthodontia Medically Necessary Orthodontia Copay Plan Coinsurance Plan Pediatric Dental EHB Up to Age 19 Up to Age 1	Summary of B	·	Children's Dental Plan				
Member Cost Share amounts describe the Enrollee's out of pocket costs. Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business. Actuarial Value 86.8% 86.8% 86.8% 86.8% 83.2% In-Network In-Network In-Network Individual Deductible Family Deductible (Two or more children) Individual Out of Pocket Maximum \$350 None \$350 None \$350 None \$350 None \$350 None \$700 None \$700 None \$700 None \$700 Waiting Period (Waivered Condition provision, as defined in Health's Safety Code 1337.50 (a)(3)(4)(4) and Insurance Code 10198.6(d) Procedure Category Procedure Category Oral Exam Preventive - Cleaning Preventive - Vicening Preventive - Vice	Summary or B	delicitis and Coverage					
Enrollee's out of pocket costs. Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business. Actuarial Value 86.8% 86.8% 83.2% In-Network Out-of-Network In-Network Individual Deductible \$65 \$65 None Family Deductible (Two or more children) Individual Out of Pocket Maximum \$350 None \$350 None \$350 Family Out of Pocket Maximum \$350 None \$700 None \$700 Office Copay \$0 \$0 \$0 Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(i)(4) and insurance Code 10198.6(i) Procedure Category Procedure Category Oral Exam Preventive - Cleaning Preventive - A-ray Preventive - X-ray Preventive - X-ray No charge Sealants per Tooth No charge 10% No charge 10% No charge 10% No charge No charge Preventive - X-ray No charge 10% No charge No charge Preventive Procedures Sealants per Tooth No charge No charge No charge 10% No charge Periodontal Maintenance Services Periodontal Maintenance Services Periodontics (other than maintenance) Endodontics Oral Surgery Otherdontia Madically Necessary Otherdontia Madically Necessary Otherdontia			Comsura	Copay Plan			
designs can be offered in both the Individual Marketplace and Covered California for Small Business. Actuarial Value			Pediatric [
Returnial Value	designs can be offered in both the Individual Marketplace and Covered California for Small		Up to Age 19		Up to Age 19		
Individual Deductible \$65 \$65 None			86.8%	86.8%	83.2%		
Family Deductible (Two or more children) \$130 \$130 Not Applicable			In-Network	Out-of-Network	In-Network		
Individual Out of Pocket Maximum \$350 None \$350	Individual Dedu	ıctible	\$65	\$65	None		
Family Out of Pocket Maximum (Two or More Children) Office Copay \$0 \$0 \$0 Waiting Period (Waivered Condition provision, as defined in Health & Safety) Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d) Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) Procedure Category Oral Exam Preventive - Cleaning Preventive - Array No charge Preventive - Variable Preventive - Var	Family Deductil	ble (Two or more children)	\$130	\$130	Not Applicable		
Children) Office Copay \$0 \$0 \$0 \$0 Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d) Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) Procedure Category Oral Exam Preventive - Cleaning Preventive Preventive Preventive Sealants per Tooth No charge Topical Fluoride Application Space Maintainers - Fixed Periodontal Maintenance Services Periodontics (other than maintenance) Endodontics Oral Surgery Oral Exam No charge No charge No charge No charge 10% No charge 1	Individual Out of	of Pocket Maximum	\$350	None	\$350		
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357,50 (a)(3)(J)(4) and Insurance Code 10198.6(d) Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) Procedure Category Oral Exam No charge Preventive Diagnostic & Preventive Preventive Diagnostic & Preventive Diagnostic & Preventive Preventive Diagnostic & Preventive Preventive Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) None Notarge 10% No charge 20% No charge 10% N	_	ocket Maximum (Two or More	\$700	None	\$700		
(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d) Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) Procedure Category Oral Exam Oral Exam No charge Preventive - Cleaning No charge Preventive - X-ray No charge Preventive - X-ray No charge Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Periodontics (other than maintenance) Endodontics Oral Surgery None	Office Copay		\$0	\$0	\$0		
Category Service Type Member Cost Share Member Cost Share Member Cost Share	(Waivered Condition provision, as defined in Health & Safety		None None		None		
Category Oral Exam Preventive - Cleaning Preventive - Sealants per Tooth Topical Fluoride Application Services Periodontics (other than maintenance) Endodontics Oral Surgery Oral Exam Preventive - Cleaning No charge Oral Surgery Oral Surgery Member Cost Share No charge 10% No			None	None	None		
Preventive - Cleaning No charge 10% No charge Preventive Sealants per Tooth No charge 10% No charge Preventive Sealants per Tooth No charge 10% No charge Topical Fluoride Application No charge 10% No charge Space Maintainers - Fixed No charge 10% No charge Preventive Procedures Periodontal Maintenance Services Periodontal Maintenance Services Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery No charge 10% No charge No charge 10% No charge Power 10% No charge No charge 10% No charge 10% No charge No charge 10% No charge 1		Service Type	Member Cost Share	Member Cost Share	Member Cost Share		
Preventive Preventive - X-ray No charge 10% No charge Sealants per Tooth No charge 10%							
Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed No charge No charge 10% No charge 10% No charge 10% No charge No charge 10% No charge 10% No charge No charge 10% No charge 1	D: # 6		ŭ .				
Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery No charge 10% 10% 10% See 2018 Dental Copay Schedule 10% 10% 10% 10% 10% 10% 10% 10% 10% 10%		•					
Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery See 2018 Dental Copay Schedule	Freventive						
Restorative Procedures Periodontal Maintenance Services Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery Restorative Procedures 20% Deductible Applies 20% Deductible Applies See 2018 Dental Copay Schedule 50% Deductible Applies Deductible Applies 50% Deductible Applies 50% Deductible Applies See 2018 Dental Copay Schedule 50% See 2018 Dental Copay Schedule							
Periodontal Maintenance Services Deductible Applies Deductible Applies Copay Schedule Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery Deductible Applies Deductible Applies 50% Deductible Applies 50% Deductible Applies 50% See 2018 Dental Copay Schedule Copay Schedule							
maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery Medically Necessary Orthodontia maintenance) 50% Deductible Applies Deductible Applies 50% Deductible Applies 50% 50% Deductible Applies 50% 50% See 2018 Dental Copay Schedule	Basic Services						
Major Services Crowns and Casts Prosthodontics Oral Surgery Deductible Applies Deductible Applies Deductible Applies Deductible Applies Deductible Applies Deductible Applies See 2018 Dental Copay Schedule	Major Services	maintenance)					
Prosthodontics Oral Surgery Deductible Applies Deductible Applies Deductible Applies Deductible Applies Deductible Applies Deductible Applies Some Some Some Some Some Some Some Some		Endodontics	50%				
Oral Surgery Orthodoptia Medically Necessary Orthodoptia 50% 50% \$350		Crowns and Casts					
Orthodontia Medically Necessary Orthodontia 50% 50% \$350		Prosthodontics					
Orthodontia Medically Necessary Orthodontia \$350		Oral Surgery					
	Orthodontia	Medically Necessary Orthodontia			\$350		



2018 DRAFT Dental Standard Benefit Plan De

Date: January 12, 2016

Summary of Benefits and Coverage		Family Dental Plan			
			Coinsura	nce Plan	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB		Adult Dental	
Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.		Up to Age 19		Age 19 and Older	
Actuarial Value		86.8%	86.8%	Not Calculated	Not Calculated
		In-Network	Out-of- Network	In-Network	Out-of- Network
Individual Dedu	ctible	\$65	\$65	\$50	\$50
Family Deductik	ole (Two or more children)	\$130	\$130	Not Applicable	Not Applicable
	of Pocket Maximum	\$350	None	Not Applicable	Not Applicable
Family Out of Pound Children)	ocket Maximum (Two or More	\$700	None	Not Applicable	Not Applicable
Office Copay		\$0	\$0	\$0	\$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d)		None	None	6 months for Major Services, Waived with Proof of Prior Coverage	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	None	\$1,500	
Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
	Oral Exam	No charge	10%	No charge	10%
Dia	Preventive - Cleaning	No charge	10%	No charge	10%
Diagnostic & Preventive	Preventive - X-ray Sealants per Tooth	No charge No charge	10% 10%	No charge Not Covered	10% Not Covered
1 TOVOILLIVO	Topical Fluoride Application	No charge	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	No charge	10%	Not Covered	Not Covered
	Restorative Procedures	20%	30%	20%	30%
Basic Services	Periodontal Maintenance	Deductible	Deductible	Deductible	Deductible
	Services	Applies	Applies	Applies	Applies
	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies
	Endodontics				
Major Services	Crowns and Casts				
	Prosthodontics		Applies		
	Oral Surgery				
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered
					Pan



2018 DRAFT Dental Standard Benefit Plan De

Date: January 12, 2016					
Summary of B	enefits and Coverage	Family Dental Plan			
		Copay Plan			
Member Cost Sh Enrollee's out of	are amounts describe the pocket costs.	Pediatric Dental EHB	Adult Dental		
designs can be o	l Plan and Family Dental Plan offered in both the Individual Covered California for Small	Up to Age 19	Age 19 and Older		
Actuarial Value		83.2%	Not Calculated		
		In-Network	In-Network		
Individual Dedu	ctible	None	None		
Family Deductik	ole (Two or more children)	Not applicable	Not Applicable		
Individual Out o	f Pocket Maximum	\$350	Not Applicable		
Family Out of Po	ocket Maximum (Two or More	\$700	Not Applicable		
Office Copay		\$0	\$0		
	provision, as defined in Health & Safety J)(4) and Insurance Code 10198.6(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	Member Cost Share		
	Oral Exam	No charge	No charge		
Dia a stia 0	Preventive - Cleaning	No charge	No charge		
Diagnostic & Preventive	Preventive - X-ray	No charge	No charge Not Covered		
i reventive	Sealants per Tooth Topical Fluoride Application	No charge No charge	Not Covered		
	Space Maintainers - Fixed	No charge	Not Covered		
Basic Services	Restorative Procedures Periodontal Maintenance Services	See 2018 Dental Copay Schedule	See 2018 Dental Copay Schedule		
Major Services	Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery	See 2018 Dental Copay Schedule	See 2018 Dental Copay Schedule		
Orthodontia	Medically Necessary Orthodontia	\$350	Not Covered		



2018 DRAFT Dental Standard Benefit Plan De

Date: January 12, 2016		Covered California for Small Business				
Summary of Benefits and Coverage		Group Dental Plan				
		Coinsurance Plan				
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB		Adult Dental		
Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.		Up to Age 19		Age 19 and Older		
Actuarial Value		86.8%	86.8%	Not Calculated	Not Calculated	
		In-Network	Out-of-Network	In-Network	Out-of-Network	
Individual Dedu	ctible	\$65	\$65	\$50	\$50	
Family Deductib	ole (Two or more children)	\$130	\$130	Not Applicable	Not Applicable	
Individual Out o	f Pocket Maximum	\$350	None	Not Applicable	Not Applicable	
Family Out of Po	ocket Maximum (Two or More	\$700	None	Not Applicable	Not Applicable	
Office Copay		\$0	\$0	\$0	\$0	
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d)		None	None	None	None	
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None	None	\$1,500		
Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	
	Oral Exam	No charge	10%	No charge	10%	
Dia a atia 0	Preventive - Cleaning	No charge	10%	No charge	10%	
Diagnostic & Preventive	Preventive - X-ray	No charge	10%	No charge	10%	
Fieventive	Sealants per Tooth Topical Fluoride Application	No charge No charge	10% 10%	Not Covered Not Covered	Not Covered Not Covered	
	Space Maintainers - Fixed	No charge	10%	Not Covered	Not Covered	
Basic Services	Restorative Procedures	20%	30%	20%	30%	
	Periodontal Maintenance Services	Deductible Applies	Deductible Applies	Deductible Applies	Deductible Applies	
Major Services	Periodontics (other than maintenance) Endodontics Crowns and Casts Prosthodontics Oral Surgery	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered	

Endnotes to 2018 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group 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) Deductible is waived for Diagnostic and Preventive Services.
- 3) Cost sharing payments made by each individual child for in-network covered 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.
- 4) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
- 5) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
- 6) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
- 7) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
- 8) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

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

- 9) Each adult is responsible for an individual deductible.
- 10) Deductible is waived for Diagnostic and Preventive Services.
- 11) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
- 12) Tooth whitening, adult orthodontia, implants and veneers are not covered services.

3) The six month waiting period for major services must be waived upon a me provision of proof of prior comprehensive dental coverage.	mber's