Adopt 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, dated July 18, 2013, which is incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c)

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Platinum Coinsurance Plan		Platinum Copay Plan		
7/18/2013						
Overall deductible			\$0		\$0	
	for specific services		ΨΟ		ΨΟ	
	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		See Dental De	sign Below	See Dental Des	sign Below
Out-of-pocket lim	it on expenses		\$4,00	0	\$4,000	0
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	е	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an inju	ıry or illness	\$20		\$20	
office or clinic	Specialist visit		\$40		\$40	
	Other practitioner office visit	unization	\$20		\$20	
	Preventive care/ screening/ imm Laboratory Tests	iui iizati0H	No cost share \$20		No cost share \$20	
Tests	X-rays and Diagnostic Imaging		\$40		\$40	
16313	Imaging (CT/PET scans, MRIs)		10%		\$150	
	Generic drugs		\$5		\$5	
Drugs to treat	Preferred brand drugs		\$15		\$15	
illness or	Non-preferred brand drugs		\$25		\$25	
condition	Specialty drugs		10%		10%	
Outpatient	Facility fee (e.g., ASC)		10%		\$250	
surgery	Physician/surgeon fees		10%			
	Emergency room services (waiv		\$150		\$150	
Need immediate attention	Emergency medical transportation Urgent care		\$150 \$40		\$150 \$40	
Hannital atau	Facility fee (e.g., hospital room)		10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days	
	Mental/Behavioral health outpat	ient services	\$20		\$20	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		10%		\$250 per day up to 5 days	
or substance abuse needs	Substance use disorder outpatient services		\$20		\$20	
	Substance use disorder inpatier	nt services	10%		\$250 per day up to 5 days	
	Prenatal care and preconception		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up	
	services	Professional	10%		to 5 days	
	Home health care Rehabilitation services		10% \$20		\$20 \$20	
Help recovering	Habilitation services		\$20		\$20	
or other special					\$150 per day up	
health needs	Skilled nursing care		10%		to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses	.=.	1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive ar Dental Basic Services		See Dental De	sign Below	See Dental Des	sign Below
	Dental Restorative and Orthodo	ntıa Services				

- 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.

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.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Gold Coinsurance Plan		lan	
7/18/2013						
Overall deductible			\$0		\$0	
Other deductibles	for specific services		Φ0.		Ф0	
	Medical Brand Drugs		\$0 \$0		\$0 \$0	
	Dental		See Dental De	sian Relow	See Dental Des	sian Below
Out-of-pocket lim			\$6,35		\$6,350	
Common Medical			Member Cost		Member Cost	
Event	Service Typ	ı c	Share	Deductible Applies	Share	Deductible Applies
Event	Cervice Typ		Onarc	Арріісэ	Onarc	Арріісэ
Visit to a health care provider's	Primary care visit to treat an inj	ury or illness	\$30		\$30	
office or clinic	Specialist visit		\$50		\$50	
	Other practitioner office visit		\$30		\$30	
	Preventive care/ screening/ imr	nunization	No cost share		No cost share	
Tasta	Laboratory Tests		\$30		\$30	
Tests	X-rays and Diagnostic Imaging		\$50		\$50	
	Imaging (CT/PET scans, MRIs) Generic drugs		20%		\$250	
Drugs to treat	Preferred brand drugs		\$19 \$50		\$19 \$50	
illness or	Non-preferred brand drugs		\$70		\$70	
condition	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC)		20%			
surgery	Physician/surgeon fees		20%		\$600	
J	Emergency room services (wai	ved if admitted)	\$250		\$250	
	Emergency medical transportation		\$250		\$250	
Need immediate attention	Urgent care		\$60		\$60	
	Facility fee (e.g., hospital room)		20%		\$600 per day up	
Hospital stay	Physician/surgeon fee		20%		to 5 days	
	Mental/Behavioral health outpa	tient services	\$30		\$30	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		20%		\$600 per day up to 5 days	
or substance abuse needs	Substance use disorder outpatient services		\$30		\$30	
	Substance use disorder inpatie	nt services	20%		\$600 per day up to 5 days	
	Prenatal care and preconception		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days	
	Home health care Rehabilitation services		20%		\$30	
Help recovering	Habilitation services		\$30 \$30		\$30 \$30	
or other special					\$300 per day up	
health needs	Skilled nursing care		20%		to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive at Dental Basic Services Dental Restorative and Orthodo		See Dental De	sign Below	See Dental Des	sign Below
	a. restoraire and ormode					

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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.
- 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.

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	enefits and Coverage		Individual	Only	Individua	l Only
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silve Coinsurand		Silver Copay Plan		
7/18/2013						
Overall deductible			N/A		N/A	
Other deductibles	for specific services					
	Medical		\$2,00		\$2,00	
	Brand Drugs		\$250		\$250	
Out–of–pocket lim	Dental it on expenses		See Dental Des \$6,35		See Dental De: \$6,35	
	it on expenses					
Common Medical Event	Service Ty	/ре	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an i	njury or illness	\$45		\$45	
office or clinic	Specialist visit		\$65		\$65	
	Other practitioner office visit		\$45		\$45	
	Preventive care/ screening/ in	nmunization	No cost share		No cost share	
Footo	Laboratory Tests	~	\$45		\$45	
Tests	X-rays and Diagnostic Imagin		\$65	X	\$65 \$350	
	Imaging (CT/PET scans, MRIs Generic drugs	>)	20% \$19	X	\$250 \$19	
Orugs to treat	Preferred brand drugs		\$50	X	\$50	Х
liness or	Non-preferred brand drugs		\$70	X	\$70	X
ondition	Specialty drugs		20%	X	20%	X
Outpatient	Facility fee (e.g., ASC)		20%		20%	
surgery	Physician/surgeon fees		20%		20%	
	Emergency room services (wa		\$250	X	\$250	Χ
	Emergency medical transportation		\$250	X	\$250	Х
Need immediate attention	Urgent care		\$90		\$90	
	Facility fee (e.g., hospital room)		20%	X		
Hospital stay	Physician/surgeon fee	,	20%	, , , , , , , , , , , , , , , , , , ,	20%	Х
	Mental/Behavioral health outp	atient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpa	tient services	20%	Х	20%	Х
or substance abuse needs	Substance use disorder outpatient services		\$45		\$45	
	Substance use disorder inpati		20%	Х	20%	Х
)	Prenatal care and preconcept		No cost share	V	No cost share	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	X	20%	Х
	Home health care	riolessional	20%		\$45	
	Rehabilitation services		\$45		\$45	
lelp recovering	Habilitation services		\$45		\$45	
or other special nealth needs	Skilled nursing care		20%	Х	20%	Х
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
Child needs	Glasses	and Diagnastic	1 pair per year		1 pair per year	
dental or eye care	Dental Basic Services Dental Basic Services	-	See Dental Des	sign Below	See Dental De	sign Below
	Dental Restorative and Office	Dental Restorative and Orthodontia Services				

- 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.

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Summary of Benefits and Coverage		SHOP C	SHOP Only		SHOP Only	
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Silver Coinsurance Plan		r Plan	
7/18/2013	7/18/2013					
Overall deductible			N/A		N/A	
	for specific services		14// (14// (
	Medical		\$1,50	10	\$1,50	0
	Brand Drugs		\$500		\$500	
	Dental		See Dental Des	sign Below	See Dental De	sign Below
Out-of-pocket lim	it on expenses		\$6,35	0	\$6,35	0
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ)e	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an inju	ury or illness	\$45		\$45	
office or clinic	Specialist visit		\$65		\$65	
	Other practitioner office visit		\$45		\$45	
	Preventive care/ screening/ imm	nunization	No cost share		No cost share	
Tooto	Laboratory Tests		\$45		\$45 \$65	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$65 20%	X	\$65 \$250	
	Generic drugs		\$19	^	\$250 \$19	
Drugs to treat	Preferred brand drugs		\$50	X	\$50	X
illness or	Non-preferred brand drugs		\$70	X	\$70	X
condition	Specialty drugs		20%	X	20%	X
Outpatient	Facility fee (e.g., ASC)		20%		20%	
surgery	Physician/surgeon fees		20%		20%	
	Emergency room services (waiv	ved if admitted)	\$250	X	\$250	Х
Need immediate attention	Emergency medical transportation		\$250	X	\$250	X
	Urgent care		\$90		\$90	
Henrital atou	Facility fee (e.g., hospital room)		20%	Х	200/	V
Hospital stay	Physician/surgeon fee		20%		20%	Х
	Mental/Behavioral health outpa	tient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpation	ent services	20%	Х	20%	Х
or substance abuse needs	Substance use disorder outpati	ent services	\$45		\$45	
	Substance use disorder inpatie	nt services	20%	Х	20%	Х
	Prenatal care and preconception	n visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	20%	Х
	services	Professional	20%			
	Home health care		20%		\$45	
Holp recovering	Rehabilitation services Habilitation services		\$45 \$45		\$45 \$45	
Help recovering or other special			Ф45		\$45	
health needs	Skilled nursing care		20%	Х	20%	Х
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
	· · · · · · · · · · · · · · · · · · ·		1 pair per year		1 pair per year	
Child poods	Glasses Dental check-up - Preventive and Diagnostic					
Child needs dental or eye care		nd Diagnostic	See Dental De	sign Below	See Dental De	sign Below

- 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.

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Summary of Benefits and Coverage

Summary of Be	SHOP UNITY			
COST SHARING	Silve	r		
	OUT OF POCKET COSTS	HSA P		
ENTOCEEE O	301 31 1 33KE1 33313	HOAT	un	
7/18/2013				
• " " "		04 500 : 4	1.14 1/5	
Overall deductible		\$1,500 integrat	ed Med/Rx	
Other deductibles	for specific services	N1/A		
	Medical	N/A		
	Brand Drugs	N/A		
0 (() ()	Dental	See Dental Des		
Out-of-pocket lim	iit on expenses	\$6,35	0	
Common Medical		Member Cost	Deductible	
Event	Service Type	Share	Applies	
	D		.,	
Visit to a health	Primary care visit to treat an injury or illness	20%	X	
care provider's				
office or clinic	Specialist visit	20%	Х	
	Other practitioner office visit	20%	X	
	Preventive care/ screening/ immunization	No cost share		
	Laboratory Tests	20%	Х	
Tests	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Daniel de la constant	Generic drugs	20%	X	
Drugs to treat	Preferred brand drugs	20%	X	
illness or	Non-preferred brand drugs	20%	Х	
condition	Specialty drugs	20%	X	
Outpatient	Facility fee (e.g., ASC)	20%	X	
surgery	Physician/surgeon fees	20%	Х	
J. J.	Emergency room services (waived if admitted)	20%	X	
	Emergency medical transportation	20%	X	
Need immediate				
attention		000/	v	
	Urgent care	20%	X	
He emited et ev	Facility fee (e.g., hospital room)	20%	X	
Hospital stay	Physician/surgeon fee	20%	X	
	Montal/Pohavioral hoalth autpatiant convices	20%	V	
	Mental/Behavioral health outpatient services	20%	Х	
Mental health,	Mental/Behavioral health inpatient services	20%	Х	
behavioral health,	iviental/behavioral fleatiff inpatient services	20 /0	^	
or substance				
abuse needs	Substance use disorder outpatient services	20%	Х	
	Outstande use disorder outpatient services	2070	^	
	Substance use disorder inpatient services	20%	X	
	<u> </u>		Λ	
	Prenatal care and preconception visits	No cost share		
Pregnancy	Delivery and all inpatient Hospital	20%	X	
	services Professional	20%	X	
	Home health care	20%	X	
	Rehabilitation services	20%	X	
Help recovering	Habilitation services	20%	Х	
or other special	Skilled nursing care	20%	Х	
health needs	•			
	Durable medical equipment	20%	X	
	Hospice service	No cost share	X	
	Eye exam (deductible waived)	0%		
Child needs	Glasses	1 pair per year		
dental or eye care	Dental Region Commission	One Devide	siam Dala	
	Dental Basic Services	See Dental Des	sign Below	
	Dental Restorative and Orthodontia Services			

SHOP Only

- 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.

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	enefits and Coverage		Individual	Only	Individua	Only
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Silver Coinsurance Plan 100%-150% FPL		ance Plan % FPL	
7/18/2013						
Overall deductible			\$0		N/A	
	for specific services		T		1,71	
	Medical		\$0		\$500	
	Brand Drugs		\$0		\$50	
	Dental		See Dental Des		See Dental De	
Out-of-pocket lim	it on expenses		\$2,25	0	\$2,25	0
Common Medical Event	Service Ty	pe	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an ir	jury or illness	\$3		\$15	
office or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ im	munization	No cost share		No cost share	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	\$3 \$5		\$15 \$20	
1 6313	Imaging (CT/PET scans, MRIs		10%		15%	X
D	Generic drugs		\$3		\$5	Α
Drugs to treat illness or	Preferred brand drugs		\$5		\$15	Х
condition	Non-preferred brand drugs		\$10		\$25	X
	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	
surgery	Physician/surgeon fees Emergency room services (wa	ived if admitted)	10% \$25		15% \$75	X
	Emergency medical transporta		\$25		\$75 \$75	X
Need immediate attention	Urgent care		\$6		\$30	
	Facility fee (e.g., hospital room	n)	10%		15%	X
Hospital stay	Physician/surgeon fee	.,	10%		15%	Λ
	Mental/Behavioral health outpa	atient services	\$3		\$15	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		10%		15%	Х
or substance abuse needs	Substance use disorder outpatient services		\$3		\$15	
	Substance use disorder inpation		10%		15%	Х
Pregnancy	Prenatal care and preconcepti		No cost share		No cost share	V
Tegnancy	Delivery and all inpatient services	Hospital Professional	10% 10%		15% 15%	X
	Home health care	, i torodolorial	10%		15%	
	Rehabilitation services		\$3		\$15	
Help recovering	Habilitation services		\$3		\$15	
or other special health needs	Skilled nursing care		10%		15%	Х
	Durable medical equipment		10%		15%	
	Hospice service Eye exam (deductible waived)		No cost share 0%		No cost share 0%	
OLUL I	Glasses		1 pair per year		1 pair per year	
Child needs dental or eye care	Dental Check-up - Preventive a Dental Basic Services		See Dental Des	sign Below	See Dental De	sign Below
	Dental Restorative and Orthoo	iontia Services				

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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.
- 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.

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Standard Benefit Flan Besigns - Final			
Summary of Benefits and Coverage	Individual Only		
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 200%-250% FPL		
7/18/2013			
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	Member Cost Deductible		

Common Medical		Member Cost	Deductible		
Event	Service Typ	е	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an inju	ıry or illness	\$40		
office or clinic	Specialist visit		\$50		
	Other practitioner office visit		\$40		
	Preventive care/ screening/ imm	nunization	No cost share		
	Laboratory Tests		\$40		
Tests	X-rays and Diagnostic Imaging		\$50		
	Imaging (CT/PET scans, MRIs)		20%	Х	
	Generic drugs		\$19		
Drugs to treat	Preferred brand drugs		\$30	Х	
illness or	Non-preferred brand drugs		\$50	Х	
condition	Specialty drugs		20%	Х	
Outpatient	Facility fee (e.g., ASC)		20%		
surgery	Physician/surgeon fees		20%		
J. ,	Emergency room services (waiv	red if admitted)	\$250	Χ	
	Emergency medical transportati		\$250	X	
Need immediate attention	Urgent care	\$80			
	Facility fee (e.g., hospital room)		20%	Х	
Hospital stay	Physician/surgeon fee		20%		
	Mental/Behavioral health outpat	Mental/Behavioral health outpatient services			
Mental health, behavioral health,	Mental/Behavioral health inpatie	ent services	20%	X	
or substance abuse needs	Substance use disorder outpatie	\$40			
	Substance use disorder inpatier	20%	X		
	Prenatal care and preconception	n visits	No cost share		
Pregnancy	Delivery and all inpatient	Hospital	20%	X	
	services	Professional	20%		
	Home health care		20%		
	Rehabilitation services		\$40		
Help recovering	Habilitation services		\$40		
or other special health needs	Skilled nursing care		20%	X	
	Durable medical equipment		20%		
	Hospice service		No cost share		
	Eye exam (deductible waived)		0%		
Obild marile	Glasses		1 pair per year		
Child needs	Dental check-up - Preventive ar	nd Diagnostic			
dental or eye care	Dental Basic Services	-	See Dental Des	sign Below	
	Dental Restorative and Orthodo	ntia Services			

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) &}quot;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.

Summary of Benefits and Coverage		Individual Only		Individual Only		
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		-	Silver Copay Plan 100%-150% FPL		ay Plan % FPL	
7/18/2013						
Overall deductible			\$0		N/A	
	for specific services		φυ		IN/A	
Other academics	Medical		\$0		\$500)
	Brand Drugs		\$0		\$50	
	Dental		See Dental Des	sian Below	See Dental De	
Out-of-pocket lim	201101		\$2,25	_	\$2,25	
Common Medical			Member Cost		Member Cost	
				Deductible		Deductible
Event	Service Typ	oe	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an inj	ury or illness	\$3		\$15	
office or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ imr	nunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests	X-rays and Diagnostic Imaging		\$5		\$20	
	Imaging (CT/PET scans, MRIs)		\$50		\$100	
Drugs to treat	Generic drugs		\$3		\$5	
illness or	Preferred brand drugs		\$5		\$15	X
condition	Non-preferred brand drugs		\$10		\$25	X
Outnotions	Specialty drugs		10%		15%	Х
Outpatient	Facility fee (e.g., ASC) Physician/surgeon fees		10% 10%		15% 15%	
surgery	Emergency room services (wai	ved if admitted)	\$25		\$75	X
	Emergency medical transportat		\$25		\$75 \$75	X
Need immediate attention	Urgent care		\$6		\$30	
Haswital stay	Facility fee (e.g., hospital room)		4.00/		450/	V
Hospital stay	Physician/surgeon fee		10%		15%	X
	Mental/Behavioral health outpa	tient services	\$3		\$15	
Mental health,	Mental/Behavioral health inpatient services		10%		15%	Х
behavioral health, or substance abuse needs	Substance use disorder outpatient services		\$3		\$15	
	Substance use disorder inpatie	nt services	10%		15%	X
	Prenatal care and preconception		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	10%		15%	Х
	services	Professional				
	Home health care Rehabilitation services		\$3 \$2		\$15 \$15	
Help recovering	Habilitation services		\$3 \$3		\$15 \$15	
or other special health needs	Skilled nursing care		10%		15%	Х
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental Check-up - Preventive at Dental Basic Services		See Dental Des	sign Below	See Dental De	sign Below
	Dental Restorative and Orthodontia Services					

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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) &}quot;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.

Summary of Be	individua	Individual Only		
COST SHARING ENROLLEE'S		Silver Copay Plan 200%-250% FPL		
7/18/2013				
Overall deductible		N/A		
	for specific services	IN/A		
Other academics	Medical	\$1,50	0	
	Brand Drugs	\$250		
	Dental	See Dental De		
Out-of-pocket lim	it on expenses	\$5,20	0	
Common Medical		Member Cost	Deductible	
Event	Service Type	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injury or illness	\$40		
office or clinic	Specialist visit	\$50		
	Other practitioner office visit	\$40		
	Preventive care/ screening/ immunization	No cost share		
Tests	Laboratory Tests	\$40 \$50		
16212	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$50 \$250		
	Generic drugs	\$19		
Drugs to treat	Preferred brand drugs	\$30	X	
illness or	Non-preferred brand drugs	\$50	X	
condition	Specialty drugs	20%	Х	
Outpatient	Facility fee (e.g., ASC)	20%		
surgery	Physician/surgeon fees	20%		
	Emergency room services (waived if admitted)	\$250	Х	
	Emergency medical transportation	\$250	Х	
Need immediate attention	Urgent care	\$80		
Hospital stay	Facility fee (e.g., hospital room)	20%	Х	
1103pital Stay	Physician/surgeon fee	2070		
	Mental/Behavioral health outpatient services	\$40		
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х	
or substance abuse needs	Substance use disorder outpatient services	\$40		
	Substance use disorder inpatient services	20%	Х	
B	Prenatal care and preconception visits	No cost share		
Pregnancy	Delivery and all inpatient Hospital services Professional	20%	Х	
	Home health care	\$40		
Holp recovering	Rehabilitation services Habilitation services	\$40 \$40		
Help recovering or other special health needs	Skilled nursing care	20%	Х	
noutili ficeus	Durable medical equipment	20%		
	Hospice service	No cost share		
	Eye exam (deductible waived)	0%		
Child needs	Glasses	1 pair per year		
dental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services	See Dental De	sign Below	
	Dental Restorative and Orthodontia Services			

Individual Only

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.

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Bronze l	Bronze Plan		Bronze HSA Plan	
7/18/2013						
Overall deductible			\$5,000 integrat	ed Med/Rx	\$4,500 integrat	ed Med/Rx
	for specific services		φο,σσο integrat	oa woartx	ψ 1,000 intograt	oa moarra
	Medical		N/A		N/A	
	Brand Drugs		N/A		N/A	
	Dental		See Dental Des	_	See Dental Des	
Out-of-pocket lim	it on expenses		\$6,35	0	\$6,35	0
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	ре	Share	Applies	Share	Applies
				After 1st 3		
Visit to a health care provider's	Primary care visit to treat an inj	ury or illness	\$60	non- preventive visits	40%	Х
office or clinic	Specialist visit		\$70	X	40%	Х
	Other practitioner office visit		\$60	X	40%	X
	Preventive care/ screening/ imr	nunization	No cost share		No cost share	
	Laboratory Tests		30%	Χ	40%	X
Tests	X-rays and Diagnostic Imaging		30%	X	40%	Х
	Imaging (CT/PET scans, MRIs)		30%	X	40%	Х
Drugs to treat	Generic drugs		\$19	Х	40%	Х
illness or	Preferred brand drugs		\$50	X	40%	Х
condition	Non-preferred brand drugs		\$75	Х	40%	Х
	Specialty drugs		30%	X	40%	X
Outpatient	Facility fee (e.g., ASC)		30%	X	40%	X
surgery	Physician/surgeon fees		30%	X	40%	X
Need immediate attention	Emergency room services (wai Emergency medical transportation		\$300 \$300	X	40% 40%	X
	Urgent care		\$120	After 1st 3 non- preventive visits	40%	X
	Facility fee (e.g., hospital room)		30%	X	40%	Х
Hospital stay	Physician/surgeon fee		30%	X	40%	X
	Mental/Behavioral health outpatient services		\$60	After 1st 3 non- preventive visits	40%	Х
Mental health, behavioral health,	Mental/Behavioral health inpatient services		30%	Х	40%	X
or substance abuse needs	Substance use disorder outpatient services		\$60	After 1st 3 non- preventive visits	40%	Х
	Substance use disorder inpatie		30%	Х	40%	Х
	Prenatal care and preconception		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	30%	X	40%	X
	services Home health care	Professional	30%	X	40%	X
	Rehabilitation services		30% 30%	X	40% 40%	X
Help recovering	Habilitation services		30%	X	40%	X
or other special health needs	Skilled nursing care		30%	X	40%	X
noutin necus	Durable medical equipment		30%	X	40%	X
	Hospice service		No cost share	X	No cost share	X
	Eye exam (deductible waived)		0%	, , , , , , , , , , , , , , , , , , ,	0%	, , , , , , , , , , , , , , , , , , ,
Obital and	Glasses		1 pair per year		1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive a Dental Basic Services			sign Below	See Dental De	sign Below
	Dental Restorative and Orthodo		See Dental Design Below		200.3.1 201011	

- 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.

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COST SHARING ENROLLEE'S	Catastrophic Plan			
7/18/2013				
1710.2010				
Overall deductible Other deductibles	for specific services		\$6,350 integrat	ed Med/Rx
	Medical		N/A	
	Brand Drugs		N/A	
	Dental		See Dental De	
Out-of-pocket lim	•		\$6,35	0
Common Medical			Member Cost	Deductible
Event	Service Typ) e	Share	Applies After 1st 3
Visit to a health care provider's	Primary care visit to treat an inju	ury or illness	0%	non- preventive visits
office or clinic	Specialist visit		0%	Х
	Other practitioner office visit		0%	Х
	Preventive care/ screening/ imn Laboratory Tests	iunization	No cost share 0%	X
Tests	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat	Generic drugs		0%	Χ
illness or	Preferred brand drugs		0%	Х
condition	Non-preferred brand drugs		0%	X
Outpatient	Specialty drugs Facility fee (e.g., ASC)		0% 0%	X
surgery	Physician/surgeon fees			
	Emergency room services (waiv	0% 0%	X	
	Emergency medical transportation		0%	Х
Need immediate attention	Urgent care	0%	After 1st 3 non- preventive visits	
Hospital stay	Facility fee (e.g., hospital room)		0%	Х
Troopital Stay	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpar	tient services	0%	After 1st 3 non- preventive visits
Mental health, behavioral health,	Mental/Behavioral health inpation	ent services	0%	Х
or substance abuse needs	Substance use disorder outpati	0%	After 1st 3 non- preventive visits	
	Substance use disorder inpatie		0%	Х
Pregnancy	Prenatal care and preconception	_	No cost share	V
Fregulaticy	Delivery and all inpatient services	Hospital Professional	0% 0%	X
	Home health care	Tioressional	0%	X
	Rehabilitation services		0%	Х
Help recovering	Habilitation services		0%	Х
or other special health needs	Skilled nursing care		0%	Х
nealth needs	Durable medical equipment		0%	Х
	Hospice service		No cost share	X
	Eye exam (deductible waived)		0%	
Child needs	Glasses	15	1 pair per year	
dental or eye care	Dental check-up - Preventive ar Dental Basic Services	nd Diagnostic	Sac Dontal Day	eign Polow
	Dental Restorative and Orthodo	ontia Services	See Dental De	sign below
	Coloranto ana Onnodo			

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

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

- 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. DEPO products must conform to the DHMO Benefit Plan Design.