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

			Platinum-Coinsurance Plan		Platinum-Copay Plan	
			Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value			89%	N/A	88%	N/A
Overall deductible			$0	$500	N/A	N/A
Other deductibles for specific services						
	Facility-related Services				$0	$500
	Brand Drugs		$0	N/A	$0	N/A
	Dental		TBD	TBD	TBD	N/A
Out–of–pocket limit on expenses			$1,250	$2,500	$1,250	N/A
Common Medical Event	**Service Type**		**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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		$20	30%	$20	Not covered
	Specialist visit		$20	30%	$20	Not covered
	Other practitioner office visit		10%	30%	$20	Not covered
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		10%	30%	$20	Not covered
	Imaging (CT/PET scans, MRIs)		10%	30%	10%	Not covered
Drugs to treat illness or condition	Generic drugs		$5	Not covered	$5	Not covered
	Preferred brand drugs		$15	Not covered	$15	Not covered
	Non-preferred brand drugs		$25	Not covered	$25	Not covered
	Specialty drugs		10%	Not covered	10%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		10%	30%	10%	Not covered
	Physician/surgeon fees		10%	30%	$100	Not covered
Need immediate attention	Emergency room services		$150	$150	$150	$150
	Emergency medical transportation		10%	30%	$150	Not covered
	Urgent care		$40	30%	$40	Not covered
Hospital stay	Facility fee (e.g., hospital room)		10%	30%	10%	Not covered
	Physician/surgeon fee		10%	30%	$200	Not covered
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$20	30%	$20	Not covered
	Mental/Behavioral health inpatient services		10%	30%	10%	Not covered
	Substance use disorder outpatient services		$20	30%	$20	Not covered
	Substance use disorder inpatient services		10%	30%	10%	Not covered
Pregnancy	Prenatal and postnatal care		$20	30%	$20	Not covered
	Delivery and all inpatient services	Professional	10%	30%	$200	Not covered
		Hospital	10%	30%	10%	Not covered
Help recovering or other special health needs	Home health care		10%	30%	$20	Not covered
	Rehabilitation services		10%	30%	$20	Not covered
	Habilitation services		10%	30%	$20	Not covered
	Skilled nursing care		10%	30%	10%	Not covered
	Durable medical equipment		10%	30%	10%	Not covered
	Hospice service		No cost share	30%	No cost share	Not covered
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	Not covered	0%	Not covered
	Glasses		$20	Not covered	$20	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	TBD	TBD	Not covered
	Dental Restorative and Orthodontia Services		TBD	TBD	TBD	Not covered

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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

			Gold-Coinsurance Plan		Gold-Copay Plan	
			Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value			81%	N/A	80%	N/A
Overall deductible			$500	$1,000	N/A	N/A
Other deductibles for specific services						
	Facility-related Services				$500	$1,000
	Brand Drugs		$100	N/A	$100	N/A
	Dental		TBD	TBD	TBD	N/A
Out–of–pocket limit on expenses			$2,500	$5,000	$2,500	N/A
Common Medical Event	**Service Type**		**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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		$30	40%	$30	Not covered
	Specialist visit		$30	40%	$30	Not covered
	Other practitioner office visit		20%	40%	$30	Not covered
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		20%	40%	$30	Not covered
	Imaging (CT/PET scans, MRIs)		20%	40%	20%	Not covered
Drugs to treat illness or condition	Generic drugs		$10	Not covered	$10	Not covered
	Preferred brand drugs		$20	Not covered	$20	Not covered
	Non-preferred brand drugs		$35	Not covered	$35	Not covered
	Specialty drugs		20%	Not covered	20%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		20%	40%	20%	Not covered
	Physician/surgeon fees		20%	40%	$150	Not covered
Need immediate attention	Emergency room services		$200	$200	$200	$200
	Emergency medical transportation		20%	40%	$150	Not covered
	Urgent care		$50	40%	$50	Not covered
Hospital stay	Facility fee (e.g., hospital room)		20%	40%	20%	Not covered
	Physician/surgeon fee		20%	40%	$250	Not covered
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$30	40%	$30	Not covered
	Mental/Behavioral health inpatient services		20%	40%	20%	Not covered
	Substance use disorder outpatient services		$30	40%	$30	Not covered
	Substance use disorder inpatient services		20%	40%	20%	Not covered
Pregnancy	Prenatal and postnatal care		$30	40%	$30	Not covered
	Delivery and all inpatient services	Professional	20%	40%	$250	Not covered
		Hospital	20%	40%	20%	Not covered
Help recovering or other special health needs	Home health care		20%	40%	$30	Not covered
	Rehabilitation services		20%	40%	$30	Not covered
	Habilitation services		20%	40%	$30	Not covered
	Skilled nursing care		20%	40%	20%	Not covered
	Durable medical equipment		20%	40%	20%	Not covered
	Hospice service		No cost share	40%	No cost share	Not covered
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	Not covered	0%	Not covered
	Glasses		$30	Not covered	$30	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	TBD	TBD	Not covered
	Dental Restorative and Orthodontia Services		TBD	TBD	TBD	Not covered

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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

			Silver-Coinsurance Plan		Silver Coins Plan-100%-150% FPL	
			Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value			71%	N/A	94%	N/A
Overall deductible			$1,000	$2,000	$0	$100
Other deductibles for specific services						
	Facility-related Services					
	Brand Drugs		$250	$500	$0	$0
	Dental		TBD	TBD	TBD	TBD
Out–of–pocket limit on expenses			$5,500	$11,000	$1,833	$3,667
Common Medical Event	**Service Type**		**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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		$40	50%	$3	25%
	Specialist visit		$40	50%	$3	25%
	Other practitioner office visit		30%	50%	5%	25%
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		30%	50%	5%	25%
	Imaging (CT/PET scans, MRIs)		30%	50%	5%	25%
Drugs to treat illness or condition	Generic drugs		$15	Not covered	$3	Not covered
	Preferred brand drugs		$25	Not covered	$5	Not covered
	Non-preferred brand drugs		$40	Not covered	$8	Not covered
	Specialty drugs		30%	Not covered	5%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		30%	50%	5%	25%
	Physician/surgeon fees		30%	50%	5%	25%
Need immediate attention	Emergency room services		$250	$250	$25	$25
	Emergency medical transportation		30%	50%	5%	25%
	Urgent care		$55	50%	$5	25%
Hospital stay	Facility fee (e.g., hospital room)		30%	50%	5%	25%
	Physician/surgeon fee		30%	50%	5%	25%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	50%	$3	25%
	Mental/Behavioral health inpatient services		30%	50%	5%	25%
	Substance use disorder outpatient services		$40	50%	$3	25%
	Substance use disorder inpatient services		30%	50%	5%	25%
Pregnancy	Prenatal and postnatal care		$40	50%	$3	25%
	Delivery and all inpatient services	Professional	30%	50%	5%	25%
		Hospital	30%	50%	5%	25%
Help recovering or other special health needs	Home health care		30%	50%	5%	25%
	Rehabilitation services		30%	50%	5%	25%
	Habilitation services		30%	50%	5%	25%
	Skilled nursing care		30%	50%	5%	25%
	Durable medical equipment		30%	50%	5%	25%
	Hospice service		No cost share	50%	No cost share	25%
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	Not covered	0%	Not covered
	Glasses		$40	Not covered	$3	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services		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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

			Silver Coins Plan-150%-200% FPL		Silver Coins Plan-200%-250% FPL	
			Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value			87%	N/A	79%	N/A
Overall deductible			$250	$500	$1,000	$2,000
Other deductibles for specific services						
	Facility-related Services					
	Brand Drugs		$0	$0	$250	$500
	Dental		TBD	TBD	TBD	TBD
Out–of–pocket limit on expenses			$1,833	$3,667	$2,750	$5,500
Common Medical Event	**Service Type**		**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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		$10	30%	$40	50%
	Specialist visit		$10	30%	$40	50%
	Other practitioner office visit		10%	30%	30%	50%
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		10%	30%	30%	50%
	Imaging (CT/PET scans, MRIs)		10%	30%	30%	50%
Drugs to treat illness or condition	Generic drugs		$10	Not covered	$15	Not covered
	Preferred brand drugs		$15	Not covered	$25	Not covered
	Non-preferred brand drugs		$20	Not covered	$40	Not covered
	Specialty drugs		10%	Not covered	30%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		10%	30%	30%	50%
	Physician/surgeon fees		10%	30%	30%	50%
Need immediate attention	Emergency room services		$100	$100	$250	$250
	Emergency medical transportation		10%	30%	30%	50%
	Urgent care		$15	30%	$55	50%
Hospital stay	Facility fee (e.g., hospital room)		10%	30%	30%	50%
	Physician/surgeon fee		10%	30%	30%	50%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$10	30%	$40	50%
	Mental/Behavioral health inpatient services		10%	30%	30%	50%
	Substance use disorder outpatient services		$10	30%	$40	50%
	Substance use disorder inpatient services		10%	30%	30%	50%
Pregnancy	Prenatal and postnatal care		$10	30%	$40	50%
	Delivery and all inpatient services	Professional	10%	30%	30%	50%
		Hospital	10%	30%	30%	50%
Help recovering or other special health needs	Home health care		10%	30%	30%	50%
	Rehabilitation services		10%	30%	30%	50%
	Habilitation services		10%	30%	30%	50%
	Skilled nursing care		10%	30%	30%	50%
	Durable medical equipment		10%	30%	30%	50%
	Hospice service		No cost share	30%	No cost share	50%
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	Not covered	0%	Not covered
	Glasses		$10	Not covered	$40	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services		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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

	Silver-Copay Plan		Silver Copay Plan 100%-150% FPL	
	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value	68%	N/A	93%	N/A
Overall deductible	N/A	N/A	N/A	N/A
Other deductibles for specific services				
Facility-related Services	$1,000	N/A	$0	N/A
Brand Drugs	$250	N/A	$0	N/A
Dental	TBD	N/A	TBD	N/A
Out–of–pocket limit on expenses	$5,500	N/A	$1,833	N/A

Common Medical Event	Service Type		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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		$40	Not covered	$3	Not covered
	Specialist visit		$40	Not covered	$3	Not covered
	Other practitioner office visit		$40	Not covered	$3	Not covered
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		$40	Not covered	$3	Not covered
	Imaging (CT/PET scans, MRIs)		30%	Not covered	5%	Not covered
Drugs to treat illness or condition	Generic drugs		$15	Not covered	$3	Not covered
	Preferred brand drugs		$25	Not covered	$5	Not covered
	Non-preferred brand drugs		$40	Not covered	$8	Not covered
	Specialty drugs		30%	Not covered	5%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		30%	Not covered	5%	Not covered
	Physician/surgeon fees		$200	Not covered	$25	Not covered
Need immediate attention	Emergency room services		$250	$250	$25	$25
	Emergency medical transportation		$150	Not covered	$25	Not covered
	Urgent care		$55	Not covered	$5	Not covered
Hospital stay	Facility fee (e.g., hospital room)		30%	Not covered	5%	Not covered
	Physician/surgeon fee		$350	Not covered	$40	Not covered
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	Not covered	$3	Not covered
	Mental/Behavioral health inpatient services		30%	Not covered	5%	Not covered
	Substance use disorder outpatient services		$40	Not covered	$3	Not covered
	Substance use disorder inpatient services		30%	Not covered	5%	Not covered
Pregnancy	Prenatal and postnatal care		$40	Not covered	$3	Not covered
	Delivery and all inpatient services	Professional	$350	Not covered	$40	Not covered
		Hospital	30%	Not covered	5%	Not covered
Help recovering or other special health needs	Home health care		$40	Not covered	$3	Not covered
	Rehabilitation services		$40	Not covered	$3	Not covered
	Habilitation services		$40	Not covered	$3	Not covered
	Skilled nursing care		30%	Not covered	5%	Not covered
	Durable medical equipment		30%	Not covered	5%	Not covered
	Hospice service		No cost share	Not covered	No cost share	Not covered
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	Not covered	0%	Not covered
	Glasses		$40	Not covered	$3	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	Not covered	TBD	Not covered
	Dental Restorative and Orthodontia Services		TBD	Not covered	TBD	Not covered

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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

			Silver Copay Plan 150%-200% FPL		Silver Copay Plan 200%-250% FPL	
			Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value			87%	N/A	79%	N/A
Overall deductible			N/A	N/A	N/A	N/A
Other deductibles for specific services						
	Facility-related Services		$250	N/A	$1,000	N/A
	Brand Drugs		$0	N/A	$250	N/A
	Dental		TBD	N/A	TBD	N/A
Out–of–pocket limit on expenses			$1,833	N/A	$2,750	N/A
Common Medical Event	**Service Type**		**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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		$10	Not covered	$40	Not covered
	Specialist visit		$10	Not covered	$40	Not covered
	Other practitioner office visit		$10	Not covered	$40	Not covered
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		$10	Not covered	$40	Not covered
	Imaging (CT/PET scans, MRIs)		10%	Not covered	30%	Not covered
Drugs to treat illness or condition	Generic drugs		$10	Not covered	$15	Not covered
	Preferred brand drugs		$15	Not covered	$25	Not covered
	Non-preferred brand drugs		$20	Not covered	$40	Not covered
	Specialty drugs		10%	Not covered	30%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		10%	Not covered	30%	Not covered
	Physician/surgeon fees		$25	Not covered	$200	Not covered
Need immediate attention	Emergency room services		$100	$100	$250	$250
	Emergency medical transportation		$50	Not covered	$150	Not covered
	Urgent care		$15	Not covered	$55	Not covered
Hospital stay	Facility fee (e.g., hospital room)		10%	Not covered	30%	Not covered
	Physician/surgeon fee		$50	Not covered	$350	Not covered
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$10	Not covered	$40	Not covered
	Mental/Behavioral health inpatient services		10%	Not covered	30%	Not covered
	Substance use disorder outpatient services		$10	Not covered	$40	Not covered
	Substance use disorder inpatient services		10%	Not covered	30%	Not covered
Pregnancy	Prenatal and postnatal care		$10	Not covered	$40	Not covered
	Delivery and all inpatient services	Professional	$50	Not covered	$350	Not covered
		Hospital	10%	Not covered	30%	Not covered
Help recovering or other special health needs	Home health care		$10	Not covered	$40	Not covered
	Rehabilitation services		$10	Not covered	$40	Not covered
	Habilitation services		$10	Not covered	$40	Not covered
	Skilled nursing care		10%	Not covered	30%	Not covered
	Durable medical equipment		10%	Not covered	30%	Not covered
	Hospice service		No cost share	Not covered	No cost share	Not covered
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	Not covered	0%	Not covered
	Glasses		$10	Not covered	$40	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	Not covered	TBD	Not covered
	Dental Restorative and Orthodontia Services		TBD	Not covered	TBD	Not covered

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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

			Silver-HSA Plan	
			Participating Providers	Non-Participating Providers
Estimated Actuarial Value			70%	N/A
Overall deductible			$1,300	$2,600
Other deductibles for specific services				
	Facility-related Services			
	Brand Drugs		$0	$0
	Dental		TBD	TBD
Out–of–pocket limit on expenses			$5,000	$10,000
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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		20%	40%
	Specialist visit		20%	40%
	Other practitioner office visit		20%	40%
	Preventive care/ screening/		No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		20%	40%
	Imaging (CT/PET scans, MRIs)		20%	40%
Drugs to treat illness or condition	Generic drugs		20%	Not covered
	Preferred brand drugs		20%	Not covered
	Non-preferred brand drugs		20%	Not covered
	Specialty drugs		20%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		20%	40%
	Physician/surgeon fees		20%	40%
Need immediate attention	Emergency room services		20%	20%
	Emergency medical transportation		20%	40%
	Urgent care		20%	40%
Hospital stay	Facility fee (e.g., hospital room)		20%	40%
	Physician/surgeon fee		20%	40%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	40%
	Mental/Behavioral health inpatient services		20%	40%
	Substance use disorder outpatient services		20%	40%
	Substance use disorder inpatient services		20%	40%
Pregnancy	Prenatal and postnatal care		20%	40%
	Delivery and all inpatient services	Professional	20%	40%
		Hospital	20%	40%
Help recovering or other special health needs	Home health care		20%	40%
	Rehabilitation services		20%	40%
	Habilitation services		20%	40%
	Skilled nursing care		20%	40%
	Durable medical equipment		20%	40%
	Hospice service		No cost share	40%
Child needs dental or eye care	Eye exam (*deductible waived*)		20%	Not covered
	Glasses		20%	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered
	Dental Basic Services		TBD	TBD
	Dental Restorative and Orthodontia Services		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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

	Bronze-Coinsurance Plan		Bronze-Copay Plan	
	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value	64%	N/A	63%	N/A
Overall deductible	$2,000	$4,000	N/A	N/A
Other deductibles for specific services				
Facility-related Services			$2,000	N/A
Brand Drugs	$750	$1,500	$500	N/A
Dental	TBD	TBD	TBD	N/A
Out–of–pocket limit on expenses	$6,350	$12,700	$6,350	N/A

Common Medical Event	Service Type		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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		$60	50%	$70	Not covered
	Specialist visit		$60	50%	$70	Not covered
	Other practitioner office visit		40%	50%	$70	Not covered
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		40%	50%	$70	Not covered
	Imaging (CT/PET scans, MRIs)		40%	50%	40%	Not covered
Drugs to treat illness or condition	Generic drugs		$20	Not covered	$20	Not covered
	Preferred brand drugs		$45	Not covered	$45	Not covered
	Non-preferred brand drugs		$60	Not covered	$60	Not covered
	Specialty drugs		40%	Not covered	40%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		40%	50%	40%	Not covered
	Physician/surgeon fees		40%	50%	$500	Not covered
Need immediate attention	Emergency room services		$250	$250	$250	$250
	Emergency medical transportation		40%	50%	$300	Not covered
	Urgent care		$75	50%	$75	Not covered
Hospital stay	Facility fee (e.g., hospital room)		40%	50%	40%	Not covered
	Physician/surgeon fee		40%	50%	$750	Not covered
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$60	50%	$70	Not covered
	Mental/Behavioral health inpatient services		40%	50%	40%	Not covered
	Substance use disorder outpatient services		$60	50%	$70	Not covered
	Substance use disorder inpatient services		40%	50%	40%	Not covered
Pregnancy	Prenatal and postnatal care		$60	50%	$70	Not covered
	Delivery and all inpatient services	Professional	40%	50%	$750	Not covered
		Hospital	40%	50%	40%	Not covered
Help recovering or other special health needs	Home health care		40%	50%	$70	Not covered
	Rehabilitation services		40%	50%	$70	Not covered
	Habilitation services		40%	50%	$70	Not covered
	Skilled nursing care		40%	50%	40%	Not covered
	Durable medical equipment		40%	50%	40%	Not covered
	Hospice service		No cost share	50%	No cost share	Not covered
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	Not covered	0%	Not covered
	Glasses		$60	Not covered	$70	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	TBD	TBD	Not covered
	Dental Restorative and Orthodontia Services		TBD	TBD	TBD	Not covered

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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.

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

			Bronze-HSA Plan		Catastrophic Plan	
			Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Estimated Actuarial Value			61%	N/A	64%	N/A
Overall deductible			$2,000	$4,000	$6,350	$12,700
Other deductibles for specific services						
	Facility-related Services					
	Brand Drugs		$0	$0	$0	$0
	Dental		TBD	TBD	TBD	TBD
Out–of–pocket limit on expenses			$6,350	$12,700	$6,350	$12,700
Common Medical Event	**Service Type**		**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 (*deductible waived for first 2 visits except Non-Participating Provides or HSA plans*)		30%	50%	0%	20%
	Specialist visit		30%	50%	0%	20%
	Other practitioner office visit		30%	50%	0%	20%
	Preventive care/ screening/		No cost share	Not covered	No cost share	Not covered
Tests	Diagnostic test (x-ray, blood work)		30%	50%	0%	20%
	Imaging (CT/PET scans, MRIs)		30%	50%	0%	20%
Drugs to treat illness or condition	Generic drugs		30%	Not covered	0%	Not covered
	Preferred brand drugs		30%	Not covered	0%	Not covered
	Non-preferred brand drugs		30%	Not covered	0%	Not covered
	Specialty drugs		30%	Not covered	0%	Not covered
Outpatient surgery	Facility fee (e.g., ambulatory surgery center)		30%	50%	0%	20%
	Physician/surgeon fees		30%	50%	0%	20%
Need immediate attention	Emergency room services		30%	30%	0%	0%
	Emergency medical transportation		30%	50%	0%	20%
	Urgent care		30%	50%	0%	20%
Hospital stay	Facility fee (e.g., hospital room)		30%	50%	0%	20%
	Physician/surgeon fee		30%	50%	0%	20%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		30%	50%	0%	20%
	Mental/Behavioral health inpatient services		30%	50%	0%	20%
	Substance use disorder outpatient services		30%	50%	0%	20%
	Substance use disorder inpatient services		30%	50%	0%	20%
Pregnancy	Prenatal and postnatal care		30%	50%	0%	20%
	Delivery and all inpatient services	Professional	30%	50%	0%	20%
		Hospital	30%	50%	0%	20%
Help recovering or other special health needs	Home health care		30%	50%	0%	20%
	Rehabilitation services		30%	50%	0%	20%
	Habilitation services		30%	50%	0%	20%
	Skilled nursing care		30%	50%	0%	20%
	Durable medical equipment		30%	50%	0%	20%
	Hospice service		No cost share	50%	No cost share	20%
Child needs dental or eye care	Eye exam (*deductible waived*)		30%	Not covered	0%	Not covered
	Glasses		30%	Not covered	0%	Not covered
	Dental check-up - Preventive and Diagnostic Services (*deductible waived*)		0%	Not covered	0%	Not covered
	Dental Basic Services		TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services		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) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of $250
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
4) "Other Practitioner Office Visits" includes Acupuncturist, Therapy Visits, and other office visits not related to Primary Care or Specialty Physicians
5) 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.