

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

DRAFT - For discussion purposes only

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS 12/12/2012		Platinum- Coinsurance Plan	Platinum- Copay Plan	Gold- Coinsurance Plan	Gold-Copay Plan
Estimated Actuarial Value		91.8%	90.3%	81.7%	80.3%
Overall deductible		\$0	N/A	\$500	N/A
Other deductibles for specific services					
Facility only (IP, ASC, and ER)			\$0		\$500
Brand Drugs		\$0	\$0	\$100	\$100
Dental		TBD	TBD	TBD	TBD
Out-of-pocket limit on expenses		\$3,000	\$3,000	\$4,500	\$4,500

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 (<i>deductible waived for first visit except Non-Par Providers or HSA plans--see footnote</i>)		\$25	\$25	\$35	\$35
	Specialist visit		\$25	\$25	\$35	\$35
	Other practitioner office visit		\$25	\$25	\$35	\$35
	Preventive care/ screening/ immunization		No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)		10%	\$25	20%	\$100
	Imaging (CT/PET scans, MRIs)		10%	\$150	20%	\$200
Drugs to treat illness or condition	Generic drugs		\$5	\$5	\$10	\$10
	Preferred brand drugs		\$15	\$15	\$20	\$20
	Non-preferred brand drugs		\$25	\$25	\$35	\$35
	Specialty drugs		10%	10%	20%	20%
Outpatient surgery	Facility fee (e.g., ASC)		10%	10%	20%	20%
	Physician/surgeon fees		10%	\$150	20%	\$200
Need immediate attention	Emergency room services (waived if admitted)		\$150	\$150	\$200	\$200
	Emergency medical transportation		\$150	\$150	\$200	\$200
	Urgent care		\$40	\$40	\$50	\$50
Hospital stay	Facility fee (e.g., hospital room)		10%	\$300 per day, up to 3 days	20%	\$600 per day, up to 3 days
	Physician/surgeon fee		10%		20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		\$25	\$25	\$35	\$35
	Mental/Behavioral health inpatient services		10%	\$300 per day, up to 3 days	20%	\$600 per day, up to 3 days
	Substance use disorder outpatient services		\$25	\$25	\$35	\$35
	Substance use disorder inpatient services		10%	\$300 per day, up to 3 days	20%	\$600 per day, up to 3 days
Pregnancy	Prenatal and postnatal care		\$25	\$25	\$35	\$35
	Delivery and all inpatient services	Professional	10%	\$300 per day, up to 3 days	20%	\$600 per day, up to 3 days
		Hospital	10%		20%	
Help recovering or other special health needs	Home health care		10%	\$25	20%	\$25
	Rehabilitation services		10%	\$25	20%	\$25
	Habilitation services		10%	\$25	20%	\$25
	Skilled nursing care		10%	\$150 per day, up to 3 days	20%	\$200 per day, up to 3 days
	Durable medical equipment		10%	10%	20%	20%
	Hospice service		No cost share	No cost share	No cost share	No cost share
Child needs dental or eye care	Eye exam(<i>deductible waived</i>)		0%	0%	0%	0%
	Glasses		1 pair per year	1 pair per year	1 pair per year	1 pair per year
	Dental check-up - Preventive and Diagnostic Services (<i>ded waived</i>)		0%	0%	0%	0%
	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) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 5) For all Coinsurance plans other than Catastrophic, deductible is waived for one office visit, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
- 6) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 8) Glasses benefit limited to \$100 per year
- 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
- 10) Orthodontia coverage is limited to medically necessary services

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Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS 12/12/2012		Silver- Coinsurance Plan	Silver Coins Plan-100%- 150% FPL	Silver Coins Plan-150%- 200% FPL	Silver Coins Plan-200%- 250% FPL
Estimated Actuarial Value		71.9%	94.8%	87.9%	76.9%
Overall deductible		\$1,200	\$0	\$400	\$1,200
Other deductibles for specific services					
Facility only (IP, ASC, and ER)					
Brand Drugs		\$200	\$0	\$25	\$200
Dental		TBD	TBD	TBD	TBD
Out-of-pocket limit on expenses		\$6,400	\$2,133	\$2,133	\$3,200
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 (<i>deductible waived for first visit except Non-Par Providers or HSA plans--see footnote</i>)	\$45	\$3	\$20	\$45
	Specialist visit	\$45	\$3	\$20	\$45
	Other practitioner office visit	\$45	\$3	\$20	\$45
	Preventive care/ screening/ immunization	No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)	30%	10%	15%	30%
	Imaging (CT/PET scans, MRIs)	30%	10%	15%	30%
Drugs to treat illness or condition	Generic drugs	\$20	\$3	\$8	\$20
	Preferred brand drugs	\$30	\$5	\$18	\$30
	Non-preferred brand drugs	\$50	\$8	\$27	\$50
	Specialty drugs	30%	10%	15%	30%
Outpatient surgery	Facility fee (e.g., ASC)	30%	10%	15%	30%
	Physician/surgeon fees	30%	10%	15%	30%
Need immediate attention	Emergency room services (waived if admitted)	\$250	\$25	\$75	\$250
	Emergency medical transportation	\$250	\$25	\$75	\$250
	Urgent care	\$60	\$8	\$30	\$60
Hospital stay	Facility fee (e.g., hospital room)	30%	10%	15%	30%
	Physician/surgeon fee	30%	10%	15%	30%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45	\$3	\$20	\$45
	Mental/Behavioral health inpatient services	30%	10%	15%	30%
	Substance use disorder outpatient services	\$45	\$3	\$20	\$45
	Substance use disorder inpatient services	30%	10%	15%	30%
Pregnancy	Prenatal and postnatal care	\$45	\$3	\$20	\$45
	Delivery and all inpatient services	30%	10%	15%	30%
		30%	10%	15%	30%
Help recovering or other special health needs	Home health care	30%	10%	15%	30%
	Rehabilitation services	30%	10%	15%	30%
	Habilitation services	30%	10%	15%	30%
	Skilled nursing care	30%	10%	15%	30%
	Durable medical equipment	30%	10%	15%	30%
	Hospice service	No cost share	No cost share	No cost share	No cost share
Child needs dental or eye care	Eye exam(<i>deductible waived</i>)	0%	0%	0%	0%
	Glasses	1 pair per year	1 pair per year	1 pair per year	1 pair per year
	Dental check-up - Preventive and Diagnostic Services (<i>ded waived</i>)	0%	0%	0%	0%
	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) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 5) For all Coinsurance plans other than Catastrophic, deductible is waived for one office visit, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
- 6) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 8) Glasses benefit limited to \$100 per year
- 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
- 10) Orthodontia coverage is limited to medically necessary services

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Estimated Actuarial Value		71.7%	94.9%	87.8%	78.1%
Overall deductible		N/A	N/A	N/A	N/A
Other deductibles for specific services					
Facility only (IP, ASC, and ER)		\$1,400	\$0	\$400	\$1,400
Brand Drugs		\$250	\$0	\$25	\$250
Dental		TBD	TBD	TBD	TBD
Out-of-pocket limit on expenses		\$6,400	\$2,133	\$2,133	\$3,200

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 (<i>deductible waived for first visit except Non-Par Providers or HSA plans--see footnote</i>)		\$45	\$3	\$20	\$45
	Specialist visit		\$45	\$3	\$20	\$45
	Other practitioner office visit		\$45	\$3	\$20	\$45
	Preventive care/ screening/ immunization		No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)		\$150	\$25	\$50	\$150
	Imaging (CT/PET scans, MRIs)		\$250	\$50	\$100	\$250
Drugs to treat illness or condition	Generic drugs		\$20	\$3	\$8	\$20
	Preferred brand drugs		\$30	\$5	\$20	\$30
	Non-preferred brand drugs		\$50	\$8	\$35	\$50
	Specialty drugs		30%	10%	15%	30%
Outpatient surgery	Facility fee (e.g., ASC)		30%	10%	15%	30%
	Physician/surgeon fees		\$250	\$50	\$100	\$250
Need immediate attention	Emergency room services (waived if admitted)		\$250	\$25	\$75	\$250
	Emergency medical transportation		\$250	\$25	\$75	\$250
	Urgent care		\$60	\$18	\$35	\$60
Hospital stay	Facility fee (e.g., hospital room)		30%	\$300 per day, up to 3 days	\$600 per day, up to 3 days	30%
	Physician/surgeon fee		0%			0%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		\$45	\$3	\$20	\$45
	Mental/Behavioral health inpatient services		30%	\$300 per day, up to 3 days	\$600 per day, up to 3 days	30%
	Substance use disorder outpatient services		\$45	\$3	\$20	\$45
	Substance use disorder inpatient services		30%	\$300 per day, up to 3 days	\$600 per day, up to 3 days	30%
Pregnancy	Prenatal and postnatal care		\$45	\$3	\$20	\$45
	Delivery and all inpatient services	Professional	0%	\$300 per day, up to 3 days	\$600 per day, up to 3 days	0%
		Hospital	30%			30%
Help recovering or other special health needs	Home health care		\$25	\$25	\$25	\$25
	Rehabilitation services		\$25	\$25	\$25	\$25
	Habilitation services		\$25	\$25	\$25	\$25
	Skilled nursing care		30%	\$300 per day, up to 3 days	\$600 per day, up to 3 days	30%
	Durable medical equipment		30%	10%	15%	30%
	Hospice service		No cost share	No cost share	No cost share	No cost share
Child needs dental or eye care	Eye exam(<i>deductible waived</i>)		0%	0%	0%	0%
	Glasses		1 pair per year	1 pair per year	1 pair per year	1 pair per year
	Dental check-up - Preventive and Diagnostic Services (<i>ded waived</i>)		0%	0%	0%	0%
	Dental Basic Services		TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services		TBD	TBD	TBD	TBD

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DESCRIBE THE ENROLLEE'S OUT
OF POCKET COSTS
12/12/2012

Estimated Actuarial Value	Silver-HSA Plan	Bronze-Coinsurance Plan	Bronze-Copay Plan	Bronze-HSA Plan	Catastrophic Plan
	71.6%	62.0%	64.8%	61.6%	57.9%
Overall deductible	\$1500 integrated Med/Rx Ded	\$3500 integrated Med/Rx Ded		\$3500 integrated Med/Rx Ded	\$6400 integrated Med/Rx Ded
Other deductibles for specific services					
Facility only (IP, ASC, and ER)			\$4500 integrated Med/Rx Ded		
Brand Drugs					
Dental	TBD	TBD	TBD	TBD	TBD
Out-of-pocket limit on expenses	\$6,400	\$6,400	\$6,400	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (<i>deductible waived for first visit except Non-Par Providers or HSA plans--see footnote</i>)	20%	\$60	\$80	30%	0%
	Specialist visit	20%	\$60	\$80	30%	0%
	Other practitioner office visit	20%	\$60	\$80	30%	0%
	Preventive care/ screening/ immunization	No cost share	No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)	20%	40%	\$200	30%	0%
	Imaging (CT/PET scans, MRIs)	20%	40%	\$350	30%	0%
Drugs to treat illness or condition	Generic drugs	20%	\$25	\$25	30%	0%
	Preferred brand drugs	20%	\$50	\$50	30%	0%
	Non-preferred brand drugs	20%	\$75	\$75	30%	0%
	Specialty drugs	20%	40%	40%	30%	0%
Outpatient surgery	Facility fee (e.g., ASC)	20%	40%	40%	30%	0%
	Physician/surgeon fees	20%	40%	\$350	30%	0%
Need immediate attention	Emergency room services (waived if admitted)	20%	\$300	\$300	30%	0%
	Emergency medical transportation	20%	\$300	\$300	30%	0%
	Urgent care	20%	\$75	\$95	30%	0%
Hospital stay	Facility fee (e.g., hospital room)	20%	40%	40%	30%	0%
	Physician/surgeon fee	20%	40%	0%	30%	0%
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20%	\$60	\$80	30%	0%
	Mental/Behavioral health inpatient services	20%	40%	40%	30%	0%
	Substance use disorder outpatient services	20%	\$60	\$80	30%	0%
	Substance use disorder inpatient services	20%	40%	40%	30%	0%
Pregnancy	Prenatal and postnatal care	20%	\$60	\$80	30%	0%
	Delivery and all inpatient services	20%	40%	0%	30%	0%
		20%	40%	40%	30%	0%
Help recovering or other special health needs	Home health care	20%	40%	\$25	30%	0%
	Rehabilitation services	20%	40%	\$25	30%	0%
	Habilitation services	20%	40%	\$25	30%	0%
	Skilled nursing care	20%	40%	40%	30%	0%
	Durable medical equipment	20%	40%	40%	30%	0%
	Hospice service	No cost share	No cost share	No cost share	No cost share	No cost share
Child needs dental or eye care	Eye exam(<i>deductible waived</i>)	0%	0%	0%	0%	0%
	Glasses	1 pair per year	1 pair per year	1 pair per year	1 pair per year	1 pair per year
	Dental check-up - Preventive and Diagnostic Services (<i>ded waived</i>)	0%	0%	0%	0%	0%
	Dental Basic Services	TBD	TBD	TBD	TBD	TBD
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- 6) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
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