



2017 PROPOSED Dental Standard Benefit Plan Designs - Coinsurance

Date: February 18, 2016

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Children's Dental Plan and Family Dental Plan designs apply to Individual Marketplace and Covered California for Small Business.

		Covered California for Small Business									
		Children's Dental Plan		Family Dental Plan				Group Dental Plan			
		Pediatric Dental EHB		Pediatric Dental EHB		Adult Dental		Pediatric Dental EHB		Adult Dental	
		Up to Age 19		Up to Age 19		Age 19 and Older		Up to Age 19		Age 19 and Older	
<b>Actuarial Value</b>		86.8%	86.8%	86.8%	86.8%	Not Calculated	Not Calculated	86.8%	86.8%	Not Calculated	Not Calculated
		<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Individual Deductible</b>		\$65	\$65	\$65	\$65	\$50	\$50	\$65	\$65	\$50	\$50
<b>Family Deductible (Two or more children)</b>		\$130	\$130	\$130	\$130	Not Applicable	Not Applicable	\$130	\$130	Not Applicable	Not Applicable
<b>Individual Out of Pocket Maximum</b>		\$350	None	\$350	None	Not Applicable	Not Applicable	\$350	None	Not Applicable	Not Applicable
<b>Family Out of Pocket Maximum (Two or More Children)</b>		\$700	None	\$700	None	Not Applicable	Not Applicable	\$700	None	Not Applicable	Not Applicable
<b>Office Copay</b>		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Waiting Period</b> <small>(Waivered Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d))</small>		None	None	None	None	6 months for Major Services, Waived with Proof of Prior Coverage	6 months for Major Services, Waived with Proof of Prior Coverage	None	None	None	None
<b>Annual Benefit Limit</b> <small>(the maximum amount the dental plan will pay in the benefit year)</small>		None	None	None	None	\$1,500		None	None	\$1,500	
Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share	Member Cost Share
<b>Diagnostic &amp; Preventive</b>	Oral Exam	0%	10%	0%	10%	0%	10%	0%	10%	0%	10%
	Preventive - Cleaning	0%	10%	0%	10%	0%	10%	0%	10%	0%	10%
	Preventive - X-ray	0%	10%	0%	10%	0%	10%	0%	10%	0%	10%
	Sealants per Tooth	0%	10%	0%	10%	Not Covered	Not Covered	0%	10%	Not Covered	Not Covered
	Topical Fluoride Application	0%	10%	0%	10%	Not Covered	Not Covered	0%	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	0%	10%	0%	10%	Not Covered	Not Covered	0%	10%	Not Covered	Not Covered
<b>Basic Services</b>	Amalgam Fill - One Surface	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies
	Periodontal Maintenance Services										
	Adult Periodontics (other than maintenance)(Group Dental Plans only)										
	Adult Endodontics (Group Dental Plans only)										
<b>Major Services</b>	Crowns and Casts	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies
	Endodontics										
	Periodontics (other than maintenance)										
	Prosthodontics										
	Oral Surgery										
<b>Orthodontia</b>	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered

**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.

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

- 8) Each adult is responsible for an individual deductible.
- 9) Deductible is waived for Diagnostic and Preventive Services.
- 10) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.