COVERED CALIFORNIA™

2017 Dental Standard Benefit Plan Designs

Date: ~~February 18, 2016~~ April 7, 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.

	Children's Dental Plan		
	Coinsurance Plan		Copay Plan
	Pediatric Dental EHB		Pediatric Dental EHB
	Up to Age 19		Up to Age 19
Actuarial Value	86.8%	86.8%	83.0%
	In-Network	**Out-of-Network**	**In-Network**
Individual Deductible	$65	$65	None
Family Deductible (Two or more children)	$130	$130	Not Applicable
Individual Out of Pocket Maximum	$350	None	$350
Family Out of Pocket Maximum (Two or More Children)	$700	None	$700
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)	None	None	None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)	None	None	None

Procedure Category	Service Type	Member Cost Share	Member Cost Share	Member Cost Share
Diagnostic & Preventive	Oral Exam	~~0%~~ No charge	10%	~~$0~~ No charge
	Preventive - Cleaning	~~0%~~ No charge	10%	~~$0~~ No charge
	Preventive - X-ray	~~0%~~ No charge	10%	~~$0~~ No charge
	Sealants per Tooth	~~0%~~ No charge	10%	~~$0~~ No charge
	Topical Fluoride Application	~~0%~~ No charge	10%	~~$0~~ No charge
	Space Maintainers - Fixed	~~0%~~ No charge	10%	~~$0~~ No charge
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	See 2017 Dental Copay Schedule
	Periodontal Maintenance Services			
	Adult Periodontics (other than maintenance) (Group Dental Plans only)			
	Adult Endodontics (Group Dental Plans only)			
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	See 2017 Dental Copay Schedule
	Endodontics			
	Crowns and Casts			
	Prosthodontics			
	Oral Surgery			
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	$350

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	Family Dental Plan			
	Coinsurance Plan			
	Pediatric Dental EHB		Adult Dental	
	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 Deductible	$65	$65	$50	$50
Family Deductible (Two or more children)	$130	$130	Not Applicable	Not Applicable
Individual Out of Pocket Maximum	$350	None	Not Applicable	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	$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
Diagnostic & Preventive	Oral Exam	~~0%~~ No charge	10%	~~0%~~ No charge	10%
	Preventive - Cleaning	~~0%~~ No charge	10%	~~0%~~ No charge	10%
	Preventive - X-ray	~~0%~~ No charge	10%	~~0%~~ No charge	10%
	Sealants per Tooth	~~0%~~ No charge	10%	Not Covered	Not Covered
	Topical Fluoride Application	~~0%~~ No charge	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	~~0%~~ No charge	10%	Not Covered	Not Covered
Basic Services	Restorative Procedures	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)				
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies	50% Deductible Applies
	Endodontics				
	Crowns and Casts				
	Prosthodontics				
	Oral Surgery				
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered

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	Family Dental Plan	
	Copay Plan	
	Pediatric Dental EHB	**Adult Dental**
	Up to Age 19	**Age 19 and Older**
Actuarial Value	83.0%	Not Calculated
	In-Network	**In-Network**
Individual Deductible	None	None
Family Deductible (Two or more children)	Not applicable	Not Applicable
Individual Out of Pocket Maximum	$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	$700	Not Applicable
Office Copay	$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
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
Diagnostic & Preventive	Oral Exam	~~$0~~ No charge	~~$0~~ No charge
	Preventive - Cleaning	~~$0~~ No charge	~~$0~~ No charge
	Preventive - X-ray	~~$0~~ No charge	~~$0~~ No charge
	Sealants per Tooth	~~$0~~ No charge	Not Covered
	Topical Fluoride Application	~~$0~~ No charge	Not Covered
	Space Maintainers - Fixed	~~$0~~ No charge	Not Covered
Basic Services	Restorative Procedures	See 2017 Dental Copay Schedule	See 2017 Dental Copay Schedule
	Periodontal Maintenance Services		
	Adult Periodontics (other than maintenance) (Group Dental Plans only)		
	Adult Endodontics (Group Dental Plans only)		
Major Services	Periodontics (other than maintenance)	See 2017 Dental Copay Schedule	See 2017 Dental Copay Schedule
	Endodontics		
	Crowns and Casts		
	Prosthodontics		
	Oral Surgery		
Orthodontia	Medically Necessary Orthodontia	$350	Not Covered

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	Covered California for Small Business			
	Group Dental Plan			
	Coinsurance Plan			
	Pediatric Dental EHB		Adult Dental	
	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 Deductible	$65	$65	$50	$50
Family Deductible (Two or more children)	$130	$130	Not Applicable	Not Applicable
Individual Out of Pocket Maximum	$350	None	Not Applicable	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	$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
Diagnostic & Preventive	Oral Exam	~~0%~~ No charge	10%	~~0%~~ No charge	10%
	Preventive - Cleaning	~~0%~~ No charge	10%	~~0%~~ No charge	10%
	Preventive - X-ray	~~0%~~ No charge	10%	~~0%~~ No charge	10%
	Sealants per Tooth	~~0%~~ No charge	10%	Not Covered	Not Covered
	Topical Fluoride Application	~~0%~~ No charge	10%	Not Covered	Not Covered
	Space Maintainers - Fixed	~~0%~~ No charge	10%	Not Covered	Not Covered
Basic Services	Restorative Procedures	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)				
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	See Basic Services	See Basic Services
	Endodontics			See Basic Services	See Basic Services
	Crowns and Casts			50% Deductible Applies	50% Deductible Applies
	Prosthodontics				
	Oral Surgery				
Orthodontia	Medically Necessary Orthodontia	50% Deductible Applies	50% Deductible Applies	Not Covered	Not Covered

Endnotes to 2017 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 and implants are not covered services.