# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | Platinum Coinsurance Plan | Platinum Copay Plan |
|---|---|---|
| **Actuarial Value - Final AV Calculator** | 88.1% | 88.0% |
| **Overall deductible** | $0 | $0 |
| **Other deductibles for specific services** | | |
| **Medical** | $0 | $0 |
| **Brand Drugs** | $0 | $0 |
| **Dental** | See attachment | See attachment |
| **Out–of–pocket limit on expenses** | $4,000 | $4,000 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $20 | | $20 | |
| | Specialist visit | | $40 | | $40 | |
| | Other practitioner office visit | | $20 | | $20 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| **Tests** | Laboratory Tests | | $20 | | $20 | |
| | X-rays and Diagnostic Imaging | | $40 | | $40 | |
| | Imaging (CT/PET scans, MRIs) | | 10% | | $150 | |
| **Drugs to treat illness or condition** | Generic drugs | | $5 | | $5 | |
| | Preferred brand drugs | | $15 | | $15 | |
| | Non-preferred brand drugs | | $25 | | $25 | |
| | Specialty drugs | | 10% | | 10% | |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 10% | | $250 | |
| | Physician/surgeon fees | | 10% | | | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $150 | | $150 | |
| | Emergency medical transportation | | $150 | | $150 | |
| | Urgent care | | $40 | | $40 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 10% | | $250 per day up to 5 days | |
| | Physician/surgeon fee | | 10% | | | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $20 | | $20 | |
| | Mental/Behavioral health inpatient services | | 10% | | $250 per day up to 5 days | |
| | Substance use disorder outpatient services | | $20 | | $20 | |
| | Substance use disorder inpatient services | | 10% | | $250 per day up to 5 days | |
| **Pregnancy** | Prenatal and postnatal care | | $20 | | $20 | |
| | Delivery and all inpatient services | Hospital | 10% | | $250 per day up to 5 days | |
| | | Professional | 10% | | | |
| **Help recovering or other special health needs** | Home health care | | 10% | | $20 | |
| | Rehabilitation services | | $20 | | $20 | |
| | Habilitation services | | $20 | | $20 | |
| | Skilled nursing care | | 10% | | $150 per day up to 5 days | |
| | Durable medical equipment | | 10% | | 10% | |
| | Hospice service | | No cost share | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | | 0% | |
| | Glasses | | 1 pair per year | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | | See attachment | |
| | Dental Basic Services | | | | | |
| | Dental Restorative and Orthodontia Services | | | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | Gold Coinsurance Plan | Gold Copay Plan |
|---|---|---|
| **Actuarial Value - Final AV Calculator** | 78.2% | 78.0% |
| **Overall deductible** | $0 | $0 |
| **Other deductibles for specific services** | | |
| **Medical** | $0 | $0 |
| **Brand Drugs** | $0 | $0 |
| **Dental** | See attachment | See attachment |
| **Out–of–pocket limit on expenses** | $6,400 | $6,400 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $30 | | $30 | |
| | Specialist visit | | $50 | | $50 | |
| | Other practitioner office visit | | $30 | | $30 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| **Tests** | Laboratory Tests | | $30 | | $30 | |
| | X-rays and Diagnostic Imaging | | $50 | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | | $250 | |
| **Drugs to treat illness or condition** | Generic drugs | | $20 | | $20 | |
| | Preferred brand drugs | | $50 | | $50 | |
| | Non-preferred brand drugs | | $70 | | $70 | |
| | Specialty drugs | | 20% | | 20% | |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 20% | | $600 | |
| | Physician/surgeon fees | | 20% | | | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $250 | | $250 | |
| | Emergency medical transportation | | $250 | | $250 | |
| | Urgent care | | $60 | | $60 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 20% | | $600 per day up to 5 days | |
| | Physician/surgeon fee | | 20% | | | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $30 | | $30 | |
| | Mental/Behavioral health inpatient services | | 20% | | $600 per day up to 5 days | |
| | Substance use disorder outpatient services | | $30 | | $30 | |
| | Substance use disorder inpatient services | | 20% | | $600 per day up to 5 days | |
| **Pregnancy** | Prenatal and postnatal care | | $30 | | $30 | |
| | Delivery and all inpatient services | Hospital | 20% | | $600 per day up to 5 days | |
| | | Professional | 20% | | | |
| **Help recovering or other special health needs** | Home health care | | 20% | | $30 | |
| | Rehabilitation services | | $30 | | $30 | |
| | Habilitation services | | $30 | | $30 | |
| | Skilled nursing care | | 20% | | $300 per day up to 5 days | |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | | 0% | |
| | Glasses | | 1 pair per year | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | | See attachment | |
| | Dental Basic Services | | | | | |
| | Dental Restorative and Orthodontia Services | | | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | Individual | Individual |
|---|---|---|
| | **Silver Coinsurance Plan** | **Silver Copay Plan** |
| **Actuarial Value - Final AV Calculator** | 68.7% | 68.3% |
| **Overall deductible** | N/A | N/A |
| **Other deductibles for specific services** | | |
| **Medical** | $2,000 | $2,000 |
| **Brand Drugs** | $250 | $250 |
| **Dental** | See attachment | See attachment |
| **Out–of–pocket limit on expenses** | $6,400 | $6,400 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $45 | | $45 | |
| | Specialist visit | | $65 | | $65 | |
| | Other practitioner office visit | | $45 | | $45 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| **Tests** | Laboratory Tests | | $45 | | $45 | |
| | X-rays and Diagnostic Imaging | | $65 | | $65 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X | $250 | |
| **Drugs to treat illness or condition** | Generic drugs | | $25 | | $25 | |
| | Preferred brand drugs | | $50 | X | $50 | X |
| | Non-preferred brand drugs | | $70 | X | $70 | X |
| | Specialty drugs | | 20% | X | 20% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 20% | X | 20% | X |
| | Physician/surgeon fees | | 20% | | | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $250 | X | $250 | X |
| | Emergency medical transportation | | $250 | X | $250 | X |
| | Urgent care | | $90 | | $90 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | | | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $45 | | $45 | |
| | Mental/Behavioral health inpatient services | | 20% | X | 20% | X |
| | Substance use disorder outpatient services | | $45 | | $45 | |
| | Substance use disorder inpatient services | | 20% | X | 20% | X |
| **Pregnancy** | Prenatal and postnatal care | | $45 | | $45 | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | | | |
| **Help recovering or other special health needs** | Home health care | | 20% | | $45 | |
| | Rehabilitation services | | $45 | | $45 | |
| | Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | | 0% | |
| | Glasses | | 1 pair per year | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | | See attachment | |
| | Dental Basic Services | | | | | |
| | Dental Restorative and Orthodontia Services | | | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | SHOP | SHOP |
|---|---|---|
| | **Silver Coinsurance Plan** | **Silver Copay Plan** |
| **Actuarial Value - Final AV Calculator** | 69.8% | 69.3% |
| **Overall deductible** | N/A | N/A |
| **Other deductibles for specific services** | | |
| **Medical** | $1,500 | $1,500 |
| **Brand Drugs** | $500 | $500 |
| **Dental** | See attachment | See attachment |
| **Out–of–pocket limit on expenses** | $6,400 | $6,400 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $45 | | $45 | |
| | Specialist visit | | $65 | | $65 | |
| | Other practitioner office visit | | $45 | | $45 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| **Tests** | Laboratory Tests | | $45 | | $45 | |
| | X-rays and Diagnostic Imaging | | $65 | | $65 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X | $250 | |
| **Drugs to treat illness or condition** | Generic drugs | | $25 | | $25 | |
| | Preferred brand drugs | | $50 | X | $50 | X |
| | Non-preferred brand drugs | | $70 | X | $70 | X |
| | Specialty drugs | | 20% | X | 20% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 20% | X | 20% | X |
| | Physician/surgeon fees | | 20% | | | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $250 | X | $250 | X |
| | Emergency medical transportation | | $250 | X | $250 | X |
| | Urgent care | | $90 | | $90 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | | | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $45 | | $45 | |
| | Mental/Behavioral health inpatient services | | 20% | X | 20% | X |
| | Substance use disorder outpatient services | | $45 | | $45 | |
| | Substance use disorder inpatient services | | 20% | X | 20% | X |
| **Pregnancy** | Prenatal and postnatal care | | $45 | | $45 | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | | | |
| **Help recovering or other special health needs** | Home health care | | 20% | | $45 | |
| | Rehabilitation services | | $45 | | $45 | |
| | Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No cost share | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | | 0% | |
| | Glasses | | 1 pair per year | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | | See attachment | |
| | Dental Basic Services | | | | | |
| | Dental Restorative and Orthodontia Services | | | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | Individual & SHOP |
|---|---|
| | **Silver HSA Plan** |
| **Actuarial Value - Final AV Calculator** | 71.5% |
| **Overall deductible** | $1500 integrated Med/Rx Ded |
| **Other deductibles for specific services** | |
| **Medical** | N/A |
| **Brand Drugs** | N/A |
| **Dental** | See attachment |
| **Out–of–pocket limit on expenses** | $6,400 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | 20% | X |
| | Specialist visit | | 20% | X |
| | Other practitioner office visit | | 20% | X |
| | Preventive care/ screening/ immunization | | No cost share | |
| **Tests** | Laboratory Tests | | 20% | X |
| | X-rays and Diagnostic Imaging | | 20% | X |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| **Drugs to treat illness or condition** | Generic drugs | | 20% | X |
| | Preferred brand drugs | | 20% | X |
| | Non-preferred brand drugs | | 20% | X |
| | Specialty drugs | | 20% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 20% | X |
| | Physician/surgeon fees | | 20% | X |
| **Need immediate attention** | Emergency room services (waived if admitted) | | 20% | X |
| | Emergency medical transportation | | 20% | X |
| | Urgent care | | 20% | X |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | 20% | X |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | 20% | X |
| | Substance use disorder inpatient services | | 20% | X |
| **Pregnancy** | Prenatal and postnatal care | | 20% | X |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | X |
| **Help recovering or other special health needs** | Home health care | | 20% | X |
| | Rehabilitation services | | 20% | X |
| | Habilitation services | | 20% | X |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | X |
| | Hospice service | | No cost share | X |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | |
| | Glasses | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | |
| | Dental Basic Services | | | |
| | Dental Restorative and Orthodontia Services | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | Silver Coinsurance Plan 100%-150% FPL | Silver Coinsurance Plan 150%-200% FPL |
|---|---|---|
| **Actuarial Value - Final AV Calculator** | 94.8% | 87.8% |
| **Overall deductible** | $0 | N/A |
| **Other deductibles for specific services** | | |
| **Medical** | $0 | $500 |
| **Brand Drugs** | $0 | $50 |
| **Dental** | See attachment | See attachment |
| **Out–of–pocket limit on expenses** | $2,250 | $2,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $3 | | $15 | |
| | Specialist visit | | $5 | | $20 | |
| | Other practitioner office visit | | $3 | | $15 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| **Tests** | Laboratory Tests | | $3 | | $15 | |
| | X-rays and Diagnostic Imaging | | $5 | | $20 | |
| | Imaging (CT/PET scans, MRIs) | | 10% | | 15% | X |
| **Drugs to treat illness or condition** | Generic drugs | | $3 | | $5 | |
| | Preferred brand drugs | | $5 | | $15 | X |
| | Non-preferred brand drugs | | $10 | | $25 | X |
| | Specialty drugs | | 10% | | 15% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 10% | | 15% | X |
| | Physician/surgeon fees | | 10% | | 15% | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $25 | | $75 | X |
| | Emergency medical transportation | | $25 | | $75 | X |
| | Urgent care | | $6 | | $30 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 10% | | 15% | X |
| | Physician/surgeon fee | | 10% | | 15% | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $3 | | $15 | |
| | Mental/Behavioral health inpatient services | | 10% | | 15% | X |
| | Substance use disorder outpatient services | | $3 | | $15 | |
| | Substance use disorder inpatient services | | 10% | | 15% | X |
| **Pregnancy** | Prenatal and postnatal care | | $3 | | $15 | |
| | Delivery and all inpatient services | Hospital | 10% | | 15% | X |
| | | Professional | 10% | | 15% | |
| **Help recovering or other special health needs** | Home health care | | 10% | | 15% | |
| | Rehabilitation services | | $3 | | $15 | |
| | Habilitation services | | $3 | | $15 | |
| | Skilled nursing care | | 10% | | 15% | X |
| | Durable medical equipment | | 10% | | 15% | |
| | Hospice service | | No cost share | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | | 0% | |
| | Glasses | | 1 pair per year | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | | See attachment | |
| | Dental Basic Services | | | | | |
| | Dental Restorative and Orthodontia Services | | | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

| COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS | **Silver Coinsurance Plan 200%-250% FPL** |
|---|---|
| **2/25/2013** | |
| **Actuarial Value - Final AV Calculator** | 73.7% |
| **Overall deductible** | N/A |
| **Other deductibles for specific services** | |
| **Medical** | $1,500 |
| **Brand Drugs** | $250 |
| **Dental** | See attachment |
| **Out–of–pocket limit on expenses** | $5,200 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $40 | |
| | Specialist visit | | $50 | |
| | Other practitioner office visit | | $40 | |
| | Preventive care/ screening/ immunization | | No cost share | |
| **Tests** | Laboratory Tests | | $40 | |
| | X-rays and Diagnostic Imaging | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| **Drugs to treat illness or condition** | Generic drugs | | $20 | |
| | Preferred brand drugs | | $30 | X |
| | Non-preferred brand drugs | | $50 | X |
| | Specialty drugs | | 20% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 20% | X |
| | Physician/surgeon fees | | 20% | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $250 | X |
| | Emergency medical transportation | | $250 | X |
| | Urgent care | | $80 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $40 | |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | $40 | |
| | Substance use disorder inpatient services | | 20% | X |
| **Pregnancy** | Prenatal and postnatal care | | $40 | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | |
| **Help recovering or other special health needs** | Home health care | | 20% | |
| | Rehabilitation services | | $40 | |
| | Habilitation services | | $40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | |
| | Glasses | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | |
| | Dental Basic Services | | | |
| | Dental Restorative and Orthodontia Services | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | Silver Copay Plan 100%-150% FPL | Silver Copay Plan 150%-200% FPL |
|---|---|---|
| **Actuarial Value - Final AV Calculator** | 94.9% | 87.7% |
| **Overall deductible** | $0 | N/A |
| **Other deductibles for specific services** | | |
| **Medical** | $0 | $500 |
| **Brand Drugs** | $0 | $50 |
| **Dental** | See attachment | See attachment |
| **Out–of–pocket limit on expenses** | $2,250 | $2,250 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $3 | | $15 | |
| | Specialist visit | | $5 | | $20 | |
| | Other practitioner office visit | | $3 | | $15 | |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| **Tests** | Laboratory Tests | | $3 | | $15 | |
| | X-rays and Diagnostic Imaging | | $5 | | $20 | |
| | Imaging (CT/PET scans, MRIs) | | $50 | | $100 | |
| **Drugs to treat illness or condition** | Generic drugs | | $3 | | $5 | |
| | Preferred brand drugs | | $5 | | $15 | X |
| | Non-preferred brand drugs | | $10 | | $25 | X |
| | Specialty drugs | | 10% | | 15% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 10% | | 15% | X |
| | Physician/surgeon fees | | | | | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $25 | | $75 | X |
| | Emergency medical transportation | | $25 | | $75 | X |
| | Urgent care | | $6 | | $30 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 10% | | 15% | X |
| | Physician/surgeon fee | | | | | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $3 | | $15 | |
| | Mental/Behavioral health inpatient services | | 10% | | 15% | X |
| | Substance use disorder outpatient services | | $3 | | $15 | |
| | Substance use disorder inpatient services | | 10% | | 15% | X |
| **Pregnancy** | Prenatal and postnatal care | | $3 | | $15 | |
| | Delivery and all inpatient services | Hospital | 10% | | 15% | X |
| | | Professional | | | | |
| **Help recovering or other special health needs** | Home health care | | $3 | | $15 | |
| | Rehabilitation services | | $3 | | $15 | |
| | Habilitation services | | $3 | | $15 | |
| | Skilled nursing care | | 10% | | 15% | X |
| | Durable medical equipment | | 10% | | 15% | |
| | Hospice service | | No cost share | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | | 0% | |
| | Glasses | | 1 pair per year | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | | See attachment | |
| | Dental Basic Services | | | | | |
| | Dental Restorative and Orthodontia Services | | | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

| COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS | Silver Copay Plan 200%-250% FPL |
|---|---|
| **2/25/2013** | |
| **Actuarial Value - Final AV Calculator** | 73.3% |
| **Overall deductible** | N/A |
| **Other deductibles for specific services** | |
| **Medical** | $1,500 |
| **Brand Drugs** | $250 |
| **Dental** | See attachment |
| **Out–of–pocket limit on expenses** | $5,200 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $40 | |
| | Specialist visit | | $50 | |
| | Other practitioner office visit | | $40 | |
| | Preventive care/ screening/ immunization | | No cost share | |
| **Tests** | Laboratory Tests | | $40 | |
| | X-rays and Diagnostic Imaging | | $50 | |
| | Imaging (CT/PET scans, MRIs) | | $250 | |
| **Drugs to treat illness or condition** | Generic drugs | | $20 | |
| | Preferred brand drugs | | $30 | X |
| | Non-preferred brand drugs | | $50 | X |
| | Specialty drugs | | 20% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 20% | X |
| | Physician/surgeon fees | | | |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $250 | X |
| | Emergency medical transportation | | $250 | X |
| | Urgent care | | $80 | |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 20% | X |
| | Physician/surgeon fee | | | |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $40 | |
| | Mental/Behavioral health inpatient services | | 20% | X |
| | Substance use disorder outpatient services | | $40 | |
| | Substance use disorder inpatient services | | 20% | X |
| **Pregnancy** | Prenatal and postnatal care | | $40 | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | | |
| **Help recovering or other special health needs** | Home health care | | $40 | |
| | Rehabilitation services | | $40 | |
| | Habilitation services | | $40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No cost share | |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | |
| | Glasses | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | |
| | Dental Basic Services | | | |
| | Dental Restorative and Orthodontia Services | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

**2/25/2013**

| | Bronze Plan | Bronze HSA Plan |
|---|---|---|
| **Actuarial Value - Final AV Calculator** | 60.4% | 59.0% |
| **Overall deductible** | $5000 integrated Med/Rx Ded | $4500 integrated Med/Rx Ded |
| **Other deductibles for specific services** | | |
| **Medical** | N/A | N/A |
| **Brand Drugs** | N/A | N/A |
| **Dental** | See attachment | See attachment |
| **Out–of–pocket limit on expenses** | $6,400 | $6,400 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | $60 | After 1st 3 non-preventive visits | 40% | X |
| | Specialist visit | | $70 | X | 40% | X |
| | Other practitioner office visit | | $60 | X | 40% | X |
| | Preventive care/ screening/ immunization | | No cost share | | No cost share | |
| **Tests** | Laboratory Tests | | 30% | X | 40% | X |
| | X-rays and Diagnostic Imaging | | 30% | X | 40% | X |
| | Imaging (CT/PET scans, MRIs) | | 30% | X | 40% | X |
| **Drugs to treat illness or condition** | Generic drugs | | $25 | X | 40% | X |
| | Preferred brand drugs | | $50 | X | 40% | X |
| | Non-preferred brand drugs | | $75 | X | 40% | X |
| | Specialty drugs | | 30% | X | 40% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 30% | X | 40% | X |
| | Physician/surgeon fees | | 30% | X | 40% | X |
| **Need immediate attention** | Emergency room services (waived if admitted) | | $300 | X | 40% | X |
| | Emergency medical transportation | | $300 | X | 40% | X |
| | Urgent care | | $120 | After 1st 3 non-preventive visits | 40% | X |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 30% | X | 40% | X |
| | Physician/surgeon fee | | 30% | X | 40% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | $60 | X | 40% | X |
| | Mental/Behavioral health inpatient services | | 30% | X | 40% | X |
| | Substance use disorder outpatient services | | $60 | X | 40% | X |
| | Substance use disorder inpatient services | | 30% | X | 40% | X |
| **Pregnancy** | Prenatal and postnatal care | | $60 | After 1st 3 non-preventive visits | 40% | X |
| | Delivery and all inpatient services | Hospital | 30% | X | 40% | X |
| | | Professional | 30% | X | 40% | X |
| **Help recovering or other special health needs** | Home health care | | 30% | X | 40% | X |
| | Rehabilitation services | | 30% | X | 40% | X |
| | Habilitation services | | 30% | X | 40% | X |
| | Skilled nursing care | | 30% | X | 40% | X |
| | Durable medical equipment | | 30% | X | 40% | X |
| | Hospice service | | No cost share | X | No cost share | X |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | | 0% | |
| | Glasses | | 1 pair per year | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | | See attachment | |
| | Dental Basic Services | | | | | |
| | Dental Restorative and Orthodontia Services | | | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

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 prenatal/postnatal visits or 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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

# Covered California
## Standard Benefit Plan Designs - FINAL
## Summary of Benefits and Coverage

| COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS | Catastrophic Plan |
|---|---|
| **2/25/2013** | |
| **Actuarial Value - Final AV Calculator** | 60.4% |
| **Overall deductible** | $6400 integrated Med/Rx Ded |
| **Other deductibles for specific services** | |
| **Medical** | N/A |
| **Brand Drugs** | N/A |
| **Dental** | See attachment |
| **Out–of–pocket limit on expenses** | $6,400 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Visit to a health care provider's office or clinic** | Primary care visit to treat an injury or illness (*see footnote*) | | 0% | After 1st 3 non-preventive visits |
| | Specialist visit | | 0% | X |
| | Other practitioner office visit | | 0% | X |
| | Preventive care/ screening/ immunization | | No cost share | |
| **Tests** | Laboratory Tests | | 0% | X |
| | X-rays and Diagnostic Imaging | | 0% | X |
| | Imaging (CT/PET scans, MRIs) | | 0% | X |
| **Drugs to treat illness or condition** | Generic drugs | | 0% | X |
| | Preferred brand drugs | | 0% | X |
| | Non-preferred brand drugs | | 0% | X |
| | Specialty drugs | | 0% | X |
| **Outpatient surgery** | Facility fee (e.g., ASC) | | 0% | X |
| | Physician/surgeon fees | | 0% | X |
| **Need immediate attention** | Emergency room services (waived if admitted) | | 0% | X |
| | Emergency medical transportation | | 0% | X |
| | Urgent care | | 0% | After 1st 3 non-preventive visits |
| **Hospital stay** | Facility fee (e.g., hospital room) | | 0% | X |
| | Physician/surgeon fee | | 0% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | | 0% | X |
| | Mental/Behavioral health inpatient services | | 0% | X |
| | Substance use disorder outpatient services | | 0% | X |
| | Substance use disorder inpatient services | | 0% | X |
| **Pregnancy** | Prenatal and postnatal care | | 0% | After 1st 3 non-preventive visits |
| | Delivery and all inpatient services | Hospital | 0% | X |
| | | Professional | 0% | X |
| **Help recovering or other special health needs** | Home health care | | 0% | X |
| | Rehabilitation services | | 0% | X |
| | Habilitation services | | 0% | X |
| | Skilled nursing care | | 0% | X |
| | Durable medical equipment | | 0% | X |
| | Hospice service | | No cost share | X |
| **Child needs dental or eye care** | Eye exam (*deductible waived*) | | 0% | |
| | Glasses | | 1 pair per year | |
| | Dental check-up - Preventive and Diagnostic | | See attachment | |
| | Dental Basic Services | | | |
| | Dental Restorative and Orthodontia Services | | | |

**Notes:**

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

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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.

6) Glasses benefit limited to $100 per year.

7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.