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
	Delivery and all inpatient services – 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
	Delivery and all inpatient services — 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%
	Delivery and all inpatient services – 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%
	Delivery and all inpatient services — 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.

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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
	Delivery and all inpatient services — 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
	Delivery and all inpatient services — 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%
	Delivery and all inpatient services – 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
	Delivery and all inpatient services — 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%
	Delivery and all inpatient services — 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:
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