

# COVERED CALIFORNIA – STANDARD BENEFIT PLAN

		SILVER COPAY PLANS						SILVER STANDARD PLAN	BRONZE	PLATINUM	GOLD	MINIMUM COVERAGE PLAN																	
		100%-150% FPL	150%-200% FPL	200% - 250% FPL	250% - 400%	PLAN	COPAY PLAN	COPAY PLAN	PLAN 21-30 YEARS																				
SINGLE / FAMILY		\$17,235 / \$35,325	\$22,980 / \$47,100	\$28,725 / \$58,875	\$45,960 / \$94,200																								
ACTUARIAL VALUE – FINAL AV CALCULATOR		APPROXIMATE COSTS INSURANCE COMPANY PAYS		95%	88%	74%	69%	62%	88%	78%	60%																		
		APPROXIMATE COSTS INDIVIDUAL PAYS		5%	12%	26%	31%	38%	12%	22%	40%																		
OVERALL DEDUCTIBLE FOR SINGLE INDIVIDUAL *		\$0	N/A	N/A	N/A			\$5,000 INTEGRATED MED/RX DEDUCTIBLE	\$0	\$0	\$6,350 INTEGRATED MED/RX DEDUCTIBLE																		
OTHER DEDUCTIBLES FOR SPECIFIC SERVICES																													
MEDICAL		\$0	\$500	\$1,500	\$2,000			N/A	\$0	\$0	N/A																		
BRAND DRUGS		\$0	\$50	\$250	\$250			N/A	\$0	\$0	N/A																		
DENTAL		\$0	\$0	\$0	\$0			\$0	\$0	\$0	\$0																		
(FOR SINGLE INDIVIDUAL*) OUT-OF-POCKET LIMIT ON EXPENSES:		\$2,250	\$2,250	\$5,200	\$6,350	\$6,350	\$4,000	\$6,350	\$6,350	\$6,350	\$6,350																		
COMMON MEDICAL EVENT	SERVICE TYPE	MEMBER COST SHARE	DEDUCTIBLE APPLIES	MEMBER COST SHARE	DEDUCTIBLE APPLIES	MEMBER COST SHARE	DEDUCTIBLE APPLIES	MEMBER COST SHARE	DEDUCTIBLE APPLIES	MEMBER COST SHARE	DEDUCTIBLE APPLIES	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	\$3		\$15		\$40		\$45		\$60	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS	\$20		\$30		0%	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS												
	SPECIALIST VISIT	\$5		\$20		\$50		\$65		\$70	X	\$40		\$50		0%	X												
	OTHER PRACTITIONER OFFICE VISIT	\$3		\$15		\$40		\$45		\$60	X	\$20		\$30		0%	X												
	PREVENTIVE CARE / SCREENING / IMMUNIZATION	NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		0%													
TESTS	LABORATORY TESTS	\$3		\$15		\$40		\$45		30%	X	\$20		\$30		0%	X												
	X-RAYS AND DIAGNOSTIC IMAGING	\$5		\$20		\$50		\$65		30%	X	\$40		\$50		0%	X												
	IMAGING (CT/PET SCANS, MRIS)	\$50		\$100		\$250		\$250		30%	X	\$150		\$250		0%	X												
DRUGS TO TREAT ILLNESS OR CONDITION	GENERIC DRUGS	\$3		\$5		\$19		\$19		\$19	X	\$5		\$19		0%	X												
	PREFERRED BRAND DRUGS	\$5		\$15	X	\$30	X	\$50	X	\$50	X	\$15		\$50		0%	X												
	NON-PREFERRED BRAND DRUGS	\$10		\$25	X	\$50	X	\$70	X	\$75	X	\$25		\$70		0%	X												
	SPECIALTY DRUGS	10%		15%	X	20%	X	20%	X	30%	X	10%		20%		0%	X												
OUTPATIENT SURGERY	FACILITY FEE (E.G., ASC)																												
	PHYSICIAN/SURGEON FEES	10%		15%		20%		20%	X	30%	X	\$250		\$600		0%	X												
NEED IMMEDIATE ATTENTION	EMERGENCY ROOM SERVICES (WAIVED IF ADMITTED)	\$25		\$75	X	\$250	X	\$250	X	\$300	X	\$150		\$250		0%	X												
	EMERGENCY MEDICAL TRANSPORTATION	\$25		\$75	X	\$250	X	\$250	X	\$300	X	\$150		\$250		0%	X												
	URGENT CARE	\$6		\$30		\$80		\$90		\$120	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS	\$40		\$60		0%	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS												
HOSPITAL STAY	FACILITY FEE (E.G., HOSPITAL ROOM)																												
	PHYSICIAN / SURGEON FEE	10%		15%	X	20%	X	20%	X	30%	X	\$250 PER DAY UP TO 5 DAYS		\$600 PER DAY UP TO 5 DAYS		0%	X												
MENTAL HEALTH, BEHAVIORAL HEALTH, OR SUBSTANCE ABUSE NEEDS	MENTAL/BEHAVIORAL HEALTH OUTPATIENT SERVICES	\$3		\$15		\$40		\$45		\$60	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS	\$20		\$30		0%	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS												
	MENTAL/BEHAVIORAL HEALTH INPATIENT SERVICES	10%		15%	X	20%	X	20%	X	30%	X	\$250 PER DAY UP TO 5 DAYS		\$600 PER DAY UP TO 5 DAYS		0%	X												
	SUBSTANCE USE DISORDER OUTPATIENT SERVICES	\$3		\$15		\$40		\$45		\$60	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS	\$20		\$30		0%	AFTER 1 <sup>ST</sup> 3 NON-PREVENTIVE VISITS												
	SUBSTANCE USE DISORDER INPATIENT SERVICES	10%		15%	X	20%	X	20%	X	30%	X	\$250 PER DAY UP TO 5 DAYS		\$600 PER DAY UP TO 5 DAYS		0%	X												
PREGNANCY	PRENATAL AND POSTNATAL CARE	NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		0%													
	DELIVERY AND ALL INPATIENT SERVICES	10%		15%	X	20%	X	20%	X	30%	X	\$250 PER DAY UP TO 5 DAYS		\$600 PER DAY UP TO 5 DAYS		0%	X												
HELP RECOVERING OR OTHER SPECIAL HEALTH NEEDS	HOME HEALTH CARE	\$3		\$15		\$40		\$45		30%	X	\$20		\$30		0%	X												
	REHABILITATION SERVICES	\$3		\$15		\$40		\$45		30%	X	\$20		\$30		0%	X												
	HABILITATION SERVICE	\$3		\$15		\$40		\$45		30%	X	\$20		\$30		0%	X												
	SKILLED NURSING CARE	10%		15%	X	20%	X	20%	X	30%	X	\$150 PER DAY UP TO 5 DAYS		\$300 PER DAY UP TO 5 DAYS		0%	X												
	DURABLE MEDICAL EQUIPMENT	10%		15%		20%		20%		30%	X	10%		20%		0%	X												
	HOSPICE SERVICE	NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		NO COST SHARE		0%													
CHILD NEEDS DENTAL OR EYE CARE	EYE EXAM (DEDUCTIBLE WAIVED)	0%		0%		0%		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		1 PAIR PER YEAR		1 PAIR PER YEAR		1 PAIR PER YEAR													
	DENTAL CHECK-UP-PREVENTIVE & DIAGNOSTIC	PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED													
	DENTAL RESTORATIVE AND ORTHODONTIA SERVICES	PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED		PEDIATRIC DENTAL STANDARD PLAN DESIGN ATTACHED													
<b>DID YOU KNOW:</b>		WHILE YOU HAVE TO PAY A MONTHLY PREMIUM, YOUR COPAYS (DUE TO FEDERAL SUBSIDY AND COST-SHARE SUBSIDY) ARE LOW.				WHILE YOU HAVE TO PAY A MONTHLY PREMIUM, YOUR COPAYS (DUE TO FEDERAL SUBSIDY AND COST-SHARE SUBSIDY) ARE LOWER.				WHILE YOU HAVE TO PAY A MONTHLY PREMIUM, YOUR PREMIUMS ARE REDUCED THRU PREMIUM ASSISTANCE (APTC).				WHILE YOU HAVE NO MONTHLY PREMIUM WITH SUBSIDY, NEARLY ALL CARE IS SUBJECT TO DEDUCTIBLE OF \$5,000/YEAR WITH EXCEPTION OF 3 NON-PREVENTIVE VISITS/YEAR TO M.D. OR URGENT CARE.				WHILE YOU HAVE NO DEDUCTIBLE, YOUR PREMIUMS AND COPAYS ARE STILL HIGH.				WHILE YOU HAVE NO DEDUCTIBLE, YOUR PREMIUMS AND COPAYS ARE STILL HIGHER.				WHILE YOU HAVE NO COPAYS, NEARLY ALL CARE IS SUBJECT TO DEDUCTIBLE OF \$6,350/YEAR WITH EXCEPTION OF 3 NON PREVENTIVE VISITS/YEAR TO MD OR URGENT CARE.			
		<b>OUT-OF-POCKET EXPENSES STOP AT \$2,250 / YEAR</b>				<b>OUT-OF-POCKET EXPENSES STOP AT \$5,200 / YEAR</b>				<b>OUT-OF-POCKET EXPENSES STOP AT \$6,350 / YEAR</b>				<b>THEN CO-PAYS ARE HIGH UNTIL EXPENSES STOP AT \$6,350 / YEAR</b>				<b>EXPENSES STOP AT \$4,000 / YEAR</b>				<b>EXPENSES STOP AT \$6,350 / YEAR</b>				<b>EXPENSES STOP AT \$6,350 / YEAR</b>			

\* FAMILY DEDUCTIBLE AND OUT-OF-POCKET LIMIT IS TWICE THE AMOUNT SHOWN.