COVERED CALIFORNIA™

~~2020~~2021 Dental Benefit Plan Designs

Date: ~~March 14, 2019~~January 9, 2020

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 can be offered in both the Individual Marketplace and Covered California for Small Business.

	Individual and 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	86.2%	86.2%	~~84.8~~85.0%
	In-Network	**Out-of-Network**	**In-Network**
Individual Deductible	$75	$75	None
Family Deductible (Two or more children)	$150	$150	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	No charge	10%	No charge
	Preventive - Cleaning	No charge	10%	No charge
	Preventive - X-ray	No charge	10%	No charge
	Sealants per Tooth	No charge	10%	No charge
	Topical Fluoride Application	No charge	10%	No charge
	Space Maintainers - Fixed	No charge	10%	No charge
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	See ~~2020~~2021 Dental Copay Schedule
	Periodontal Maintenance Services			
Major Services	Periodontics (other than maintenance)	50% Deductible Applies	50% Deductible Applies	See ~~2020~~2021 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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Children's Dental Plan and Family Dental Plan designs can be offered in both the Individual Marketplace and Covered California for Small Business.

	Individual and Small Business			
	Family Dental Plan			
	Coinsurance Plan			
	Pediatric Dental EHB		Adult Dental	
	Up to Age 19		Age 19 and Older	
Actuarial Value	86.2%	86.2%	Not Calculated	Not Calculated
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Individual Deductible	$75	$75	$50	$50
Family Deductible (Two or more children)	$150	$150	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	No charge	10%	No Charge	10%
	Preventive - Cleaning	No charge	10%	No Charge	10%
	Preventive - X-ray	No charge	10%	No Charge	10%
	Sealants per Tooth	No charge	10%	No Charge if Covered	10% if Covered
	Topical Fluoride Application	No charge	10%	No Charge if Covered	10% if Covered
	Space Maintainers - Fixed	No charge	10%	No Charge if Covered	10% if Covered
Basic Services	Restorative Procedures	20% Deductible Applies	30% Deductible Applies	20% Deductible Applies	30% Deductible Applies
	Periodontal Maintenance Services				
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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	Individual and Small Business	
	Family Dental Plan	
	Copay Plan	
	Pediatric Dental EHB	**Adult Dental**
	Up to Age 19	**Age 19 and Older**
Actuarial Value	~~84.8~~85.0%	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	No charge	No Charge
	Preventive - Cleaning	No charge	No Charge
	Preventive - X-ray	No charge	No Charge
	Sealants per Tooth	No charge	No Charge if Covered
	Topical Fluoride Application	No charge	No Charge if Covered
	Space Maintainers - Fixed	No charge	No Charge if Covered
Basic Services	Restorative Procedures	See ~~2020~~2021 Dental Copay Schedule	See ~~2020~~2021 Dental Copay Schedule
	Periodontal Maintenance Services		
Major Services	Periodontics (other than maintenance)	See ~~2020~~2021 Dental Copay Schedule	See ~~2020~~2021 Dental Copay Schedule
	Endodontics		
	Crowns and Casts		
	Prosthodontics		
	Oral Surgery		
Orthodontia	Medically Necessary Orthodontia	$350	Not Covered