# INDIVIDUAL AND SMALL GROUP MARKET REPRESENTATIVE BENEFIT PLAN DESIGN WORKSHEET

Pursuant to Health and Safety Code Section 1363 subdivision (b)(1) health plans are required to provide a uniform health plan benefits and coverage matrix disclosing the health plan's covered services and associated cost-share for each Individual and/or Small Group health care service plan contract (Schedule of Benefit).

Health plans offering Individual and/or Small Group contracts may submit this template worksheet or similar worksheet capturing covered services and associated cost-share together with a Representative Schedule of Benefit populated for use in connection with the California Health Benefit Exchange's 2022 Individual Silver 70 plan to demonstrate the health plan's compliance with Section 1363 subdivision (b)(1) Representative Schedule of Benefits). **Note: Health plans may access the Representative Worksheet in the "Downloads" section of the e-File webportal.**

Health plans offering only Small Group contracts may attach a Sample Schedule of Benefit exhibit populated for use in connection with the California Health Benefit Exchange's 2022 CCSB Silver 70 copay or coinsurance plan.

## INSTRUCTIONS

Where a benefit plan design carries a deductible, health plans utilizing this worksheet must denote whether the deductible applies to a specific benefit by marking the section entitled **Deductible Applies** with "Y" in connection with services subject to the deductible or "N" in connection with services not subject to the deductible.

Health plans deviating from the California Health Benefit Exchange's standard benefit plan designs must provide justification for each deviation in the section entitled **Deviation from SBD**. Justifications include but are not limited to deviations required to comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) or any California Health Benefit Exchange approved deviations. Health plans must clearly specify the benefit plan design(s) subject to the deviation under this section.

**Service Category** is defined to include Essential Health Benefits (EHB) within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

**Service Category** also includes basic health care services, as defined in Health and Safety Code Section 1345 subdivision (b) and the health benefits covered by the Kaiser

Foundation Health Plan Small Group HMO 30 plan offered during the first quarter of 2014 (Benchmark Plan).

**Service** is defined as a sub-classification of a **Service Category**, which specifically describes the service, benefit, and/or setting where a health service is provided. For example, the applicable sub-classifications for the provision or prescription drugs would include Tier 1; Tier 2; Tier 3; and Tier 4. The sub-classifications for the provision of Physician Services would include Primary care visit to treat an injury, illness, or condition; other practitioner office visit; specialist visit; and preventive care.

**Note**: health plans must populate their Service Category and Service to mirror the sub-classifications, terms, and descriptions disclosed in the Representative Schedule of Benefits provided to the DMHC.

Health plans must disclose benefits and associated cost-share under the appropriate tab(s) that correspond to benefit plan design product type(s) (i.e. HMO, PPO, EPO). Health plans offering out-of-network benefits must disclose both in-network and out-of-network cost-share. Health plans may distinguish between in-network and out-of-network cost-share in any reasonable format, including but not limited to, use of punctuation (i.e. Inpatient Services $600 per day up to 5 days(IN)***/***40% (OON)).

Health plans must denote year-over-year changes (i.e. redlines) when revising cost-share. Health plans may provide such denotations in any form so long as it is readily understood (i.e. highlighting the appropriate cells or utilizing strikethrough).

For dental benefits, please refer to the QDP Checklist.

**Note:** Health plans electing to use this worksheet may include non-standard benefit plan designs, if applicable. Worksheets corresponding to the appropriate product type are provided to capture non-standard product(s). If additional worksheets are required, health plans may replicate the template worksheets provided in connection with non-standard product(s), as required.

*Use of the Representative Worksheet is optional. Health plans may elect to submit the required information needed to demonstrate compliance with Section 1363 (b)(1) by filing individualized Schedules of Benefits for each benefit plan design offered in the Individual and/or Small Group markets.*

*By electing to use the Representative Worksheet the health plan affirms the Representative Schedule of Benefits submitted mirrors the health plan's Schedule of Benefits for each individual and/or small group contract included in the worksheet with exception of cost-sharing information, which will vary for each benefit plan design. Health plan affirms any revisions made to the representative Schedule of Benefits will be applied to all Plan documents that contain similar language or provisions, as appropriate, irrespective of whether such documents are filed or not.*

*The DMHC reserves the right to request health plans submit individualized Schedules of Benefits for each benefit plan design offered in the Individual and/or Small Group market if the quality of the worksheet submitted is not sufficient and the terms of each benefit plan design are not readily understood upon review.*