

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)

Online Single Streamlined Application



PREVIEW PLANS

Answer a few questions and we'll show you health plans that may be right for you and your family.

[Preview Plans](#)

WELCOME TO COVERED CALIFORNIA

The place to find the best health care coverage for you and your family.

Covered California is a marketplace for people and small businesses to buy health insurance. We help you choose a plan that works best for your health care needs and your budget. You may even be able to get help paying for your health care!

Announcements

Health Insurance Plan Quality 10/28/2014
See how well the health plans are doing!

[View all Announcements](#)


Covered California can help!



INDIVIDUAL OR FAMILY

Learn more about health care plans for yourself or your family.

[Go](#)



EMPLOYER

Learn more about health care plans for your employees.

[Go](#)



EMPLOYEE

Click here if you work for a small business that buys health insurance through Covered California.

[Go](#)

CERTIFIED ENROLLMENT COUNSELORS & INSURANCE AGENTS

Certified Enrollment Counselors, Certified Insurance Agents, and Certified Enrollment Entities are comprised of trusted and known organizations and individuals. They help consumers learn, navigate, and apply for Covered California Health Plans offered by Covered California. If you are a Certified Enrollment Counselor, Certified Insurance Agent, or Certified Enrollment Entity, click [Go to Enrollment Counselor Homepage](#).

[Learn](#)[See Health Plans](#)[APPLY](#)[Renew](#)

PREVIEW PLANS





Find out if you may qualify for help to lower your health care costs.

Answer these questions to find out if your household might qualify for programs and discounts. Then apply so we can find exactly what benefits you qualify for.

Questions


What is your Zip code? * 

What is your total household income per year? * 


How many people are in your household? * 

Select One 

Age of Head of Household *

Is anyone in your household pregnant? * 

Yes No

Is anyone in your household blind or disabled? * 

Yes No

[Back](#)[See My Results](#)

[Learn](#)[See Health Plans](#)[APPLY](#)[Renew](#)

MY OPTIONS



Here is what you told us:

| | |
|---------------------------|---|
| Zip Code: | 90606 |
| Total household income: | \$30,000 |
| Household members: | 2 |
| Age of Head of Household: | 30 years |
| Age of Person 2 : | 8 years |
| Household Includes: | <input type="checkbox"/> Pregnant <input type="checkbox"/> Blind or Disabled |

Based on what you told us, here is what you may qualify for:

Available Programs

| | | | |
|--|--|--|--|
| <p>You May Qualify for:</p> <p>Free or Low-Cost Coverage</p> <p>Through Medi-Cal</p> <p>Fact Sheet</p> | <p>Access for Infants and Mothers</p> <p>(AIM)</p> <p>Fact Sheet</p> | <p>You May Qualify for:</p> <p>Discounts</p> <p>On health plans offered through Covered California</p> <p>Fact Sheet</p> | <p>Negotiated Prices</p> <p>On health plans offered through Covered California</p> <p>Fact Sheet</p> |
|--|--|--|--|

[Preview Plans](#)

You must apply so we can find exactly what benefits you qualify for.

[Back](#)[Apply Now](#)

Learn

See Health Plans

APPLY

Renew

CREATE AN ACCOUNT

Tell us about you. What kind of a user are you?



INDIVIDUAL OR FAMILY

I am an individual interested in getting health insurance for myself or my family.

Continue



EMPLOYER

I represent a small business and we are interested in setting up insurance plans for our employees.

Continue



EMPLOYEE

I am an employee of a small business that offers health benefits through Covered California.

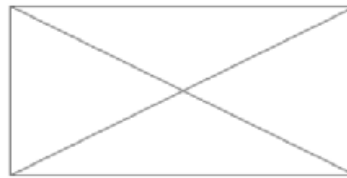
Continue



CERTIFIED ENROLLMENT COUNSELOR

I help others select insurance as a Covered California Certified Enrollment Counselor.

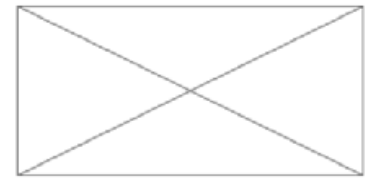
Continue



CERTIFIED INSURANCE AGENT

I help others select insurance as a Covered California Certified Insurance Agent.

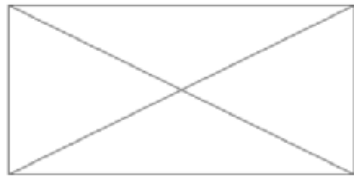
Continue



CERTIFIED ENROLLMENT ENTITY

I am a Covered California Certified Enrollment Entity Representative.

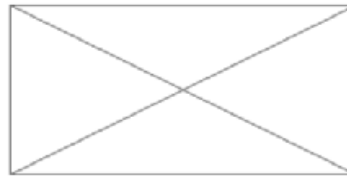
Continue



ISSUER

I am a Covered California Issuer.

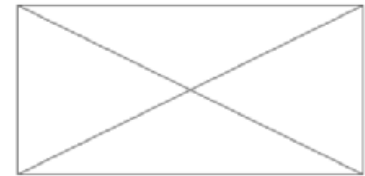
Continue



EMPLOYER REPRESENTATIVE

I am a Covered California Certified Employer Representative.

Continue



AUTHORIZED REPRESENTATIVE

I am a Covered California Certified Authorized Representative.

Continue

Learn

See Health Plans

APPLY

Renew



SET UP AN ACCOUNT

1. Terms and Conditions

2. User Information

3. Contact Information

4. Username/Password

5. Account Summary


ACCOUNT TERMS AND CONDITIONS OF USE

Welcome to the Covered California portal. If you use this this website, you agree to the terms and conditions of use and our privacy policy. If you disagree with any part of these terms and conditions, please do not use our website.

[View the Terms and Conditions](#) Check this box to show you agree to Terms and Conditions[Continue](#)

[Learn](#)[See Health Plans](#)[APPLY](#)[Renew](#)**SET UP AN ACCOUNT****SET UP AN ACCOUNT - YOUR INFORMATION**[✓ Terms and Conditio...](#)

* Indicates a required field.

*First Name *Last Name *Date of Birth  Social Security Number  *Preferred method of communication [Back](#)[Continue](#)

Learn

See Health Plans

APPLY

Renew



CREATE ACCOUNT - CONTACT INFORMATION

* Indicates a required field.

Street Address 1 Street Address 2 City State Zip Code * Email Phone Number [Back](#)[Continue](#)

Learn

Renew



Confirm Your Mailing Address

The address you've entered is different from those on file. Please confirm which is correct.

The address you entered

- 123 Main St.,
Los Angeles,
CA,
90606

Possible Address 1

- ,
CA,
CA,
90606

Possible Address 1

- ,
CA,

Ok

Back

Continue

[Learn](#)[See Health Plans](#)[APPLY](#)[Renew](#)

CREATE ACCOUNT - USERNAME & PASSWORD

* Indicates a required field.

Your Username must have 8 or more characters.


*Username 

Your Password must have 6 or more characters, 1 letter or more,
1 number or more.

*Password 

*Re-enter Password 

Your Electronic Signature PIN must have 4 numbers.

*Electronic PIN 

*Re-enter PIN 

[Back](#)[Continue](#)

[Learn](#)[See Health Plans](#)**APPLY**[Renew](#)

WELCOME, JOSH

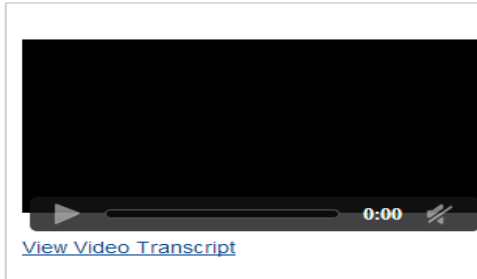
You may be eligible for a \$0 premium plan, or a new kind of tax credit that lowers your monthly premiums right away.

[Apply Now](#)

THE COVERED CALIFORNIA MARKETPLACE

When you shop at Covered California, everything you need is laid out for you. Information about prices and benefits is written in simple terms, so you don't have to guess about your costs. You get a clear picture of what you're paying and what you're getting before you make a choice.

APPLY FOR COVERAGE



Private insurance companies compete for your business in the Covered California marketplace. By law, insurance companies can't deny you coverage because of pre-existing or chronic conditions like cancer or diabetes. Watch the video tutorials on how to apply, or click [Apply Now](#)

ANNOUNCEMENTS

New Self approval account creation 08/02/2013
text

[View all Announcements](#)

RESOURCES

[Manage Delegates](#)
[Download PDF Application](#)
[Get Adobe PDF Reader](#)

MORE OPTIONS

[Register to vote](#)
[Apply as Employee](#)

DID YOU KNOW?

If you already have affordable health insurance, you can keep it and no future action is required. If for some reason you find yourself without health insurance in the future, please visit us again.

Learn**See Health Plans****APPLY****Renew**

Josh Smith

**START****Overview**

Start Here

Consent For Verificati...

OVERVIEW

Welcome to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). We will guide you through these steps for getting health insurance.



Enter your information

Tell us who wants health insurance. If you want to apply for help paying for health insurance, we will also ask about your household and your total income.



See your results

We will show your health insurance options and explain next steps. If you apply for help paying for health insurance, we will also show if you qualify.



Find health care plans

Depending on your results, you can see what health plans are available, compare them, and enroll in the health plan you choose.

Back**Save & Exit****Continue**

Learn**See Health Plans****APPLY****Renew**Josh Smith
Account #: 5372

START

✓ Overview

Start Here


Consent For Verificati...

APPLY FOR BENEFITS




Start Here

Welcome to the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)! CalHEERS uses information about your household to give you health insurance choices. It takes about 30 minutes to apply. It helps to have these things ready:

- Contact Information
- Demographic Information 
- Latest tax Information
- Current Income Information

Once you apply, we will see if you qualify. If you qualify, you may be able to join health plan.

Covered California includes programs that help Californians access affordable health coverage. These programs can help a family of four with an annual income of upto \$96,000 pay for their insurance.

Would you like to see if these programs are right for you? * Yes No 

How many members are in the household? *

How did you hear about the Exchange?

[Back](#)[Continue](#)

Learn**See Health Plans****APPLY****Renew**

Josh Smith

Account #: 5372

START

✓ Overview

✓ Start Here

Consent For Verification

START - CONSENT FOR VERIFICATION

Permission to let Covered California verify my information

We use outside governmental sources to check some of your Personally Identifiable Information (PII), like Social Security Number, tax data, and date of birth. Please check the box below to agree to let us check your PII.

 I agree to consent for Verification

Back

Save & Exit

Continue

Learn**See Health Plans****APPLY****Renew**Josh Smith
Account #: 5372**HOUSEHOLD****Introduction**

Primary Contact

Josh Smith

Member 2

Relationships

Summary



HOUSEHOLD INTRODUCTION

Coming Up In This Section

In this section, you will be asked about all the family members who live with you, even if they don't want health insurance right now. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health insurance.)

This information help us make sure everyone who wants health insurance gets as much help paying for it as possible.

You may need:

- Social Security
- Birth dates
- Most recent tax filing

Estimated time to complete:

- 15 minutes

[Back](#)[Save & Exit](#)[Continue](#)

Learn

See Health Plans

APPLY

Renew

Josh Smith
Account #: 5372

HOUSEHOLD



HOUSEHOLD PRIMARY CONTACT

Please check the information below. You can also change your primary contact below.

▼ Primary Contact - Name

First Name *

Middle Name

Last Name *

Suffix

Home Phone Number

Work Phone Number

Ext.

Cell Phone Number

Email

✓ Introduction

Primary Contact

Josh Smith

Member 2

Relationships

Summary

Street Address *

123 Main St.

Apartment or Suite Number

City *

Los Angeles

State *

CA

Zip Code *

90606

No permanent Home Address

▼ Primary Contact - Mailing Address

Is the primary contact's Mailing Address the same as the Home Address? Yes No

▼ Communication and Language Preferences

What is your preferred method of communication? 

EMail

What is the preferred written language of communication? 

English

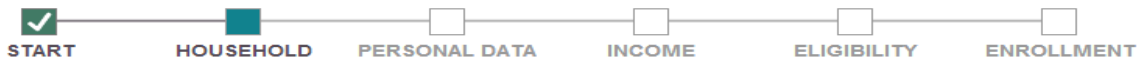
What is the preferred spoken language of communication? 

English

Back

Save & Exit

Continue

Learn**See Health Plans****APPLY****Renew**Josh Smith
Account #: 5372**HOUSEHOLD** Introduction Primary Contact**Josh Smith**



Member 2

Relationships

Summary

HOUSEHOLD MEMBERS 

Please enter all required (*) household member information below.

| | |
|---|---|
| First Name * | <input type="text" value="Josh"/> |
| Middle Name | <input type="text"/> |
| Last Name * | <input type="text" value="Smith"/> |
| Suffix | <input type="text" value="Select One"/> |
| Is this person applying for health coverage at this time? * | <input type="radio"/> Yes <input type="radio"/> No |
| Gender * | <input type="text" value="Select One"/> |
| Date of Birth * | <input type="text" value="MM/DD/YYYY"/>  |
| Does this person have a Social Security Number? * | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Social Security Number *  | <input type="text"/> <input type="text"/> <input type="text"/> |
| Is this person a U.S. citizen or U.S. national? * | <input type="radio"/> Yes <input type="radio"/> No |
| <input type="button" value="Add Member"/> <input type="button" value="Remove Member"/> | |


Learn | **See Health Plans** | **APPLY** | **Renew**

- Josh Smith
- Account #: 5372
- HOUSEHOLD**
- ✓ Introduction
- ✓ Primary Contact
- ✓ Josh Smith
- Member 2**
- Relationships
- Summary



HOUSEHOLD MEMBERS

Please enter all required (*) household member information below.

| | |
|---|---|
| First Name * | <input type="text" value="Jane"/> |
| Middle Name | <input type="text"/> |
| Last Name * | <input type="text" value="Smith"/> |
| Suffix | <input type="text" value="Select One"/> |
| Is this person applying for health coverage at this time? * | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| Gender* | <input type="text" value="Female"/> |
| Date of Birth * | <input type="text" value="12/01/1980"/>  |

Please provide a Social Security Number (SSN) if this person is applying for health coverage. If this person doesn't have an SSN, we can help apply for one. Go to www.placeholder.gov. We only use SSNs to check information like income to see if there is other help to pay for health coverage. An SSN can also help an applicant join a health plan if qualified.

Does this person have a Social Security Number? * Yes No

Social Security Number * 

| | | |
|-----|----|------|
| *** | ** | 4400 |
|-----|----|------|

Is this person a U.S. citizen or U.S. national? * Yes No

Is this person a Naturalized citizen? * Yes No

Add Member

Remove Member

Back

Save & Exit

Continue

[About Us](#) | [Mission Statement](#) | [Contact Us](#) | [Links to External Services](#)

Follow Us:



Build Version Id 11363 | Runmode: dev | Current date/time from TimeShifter: Mon Aug 26 13:37:42 PDT 2013 |

Env name: AT02 | [TimeShifter](#) | [Developer Console](#) |


Learn | See Health Plans | **APPLY** | Renew

- Josh Smith
Account #: 5372
- HOUSEHOLD
- ✓ Introduction
- ✓ Primary Contact
- ✓ Josh Smith
- ✓ Jane Smith
- Relationships**
- Summary



FAMILY RELATIONSHIPS

Tell us how your household members are related:

| This person | is... ? | to... |
|-------------|--|------------|
| Josh Smith | Select One  | Jane Smith |

Learn**See Health Plans****APPLY****Renew**Josh Smith
Account #: 5372

PERSONAL DATA

Introduction

Address & Contact

Demographic Data

Tax Information

Health Care

Optional Data

Summary



APPLICANTS INTRODUCTION

Coming Up In This Section

In this section, you will be asked additional questions about the people in your household who want health insurance. First we will ask for personal data, such as citizenship and immigration status. Then we will ask for current health care information. We ask about this information to let you know the coverage you qualify for and if you can get help paying for it.

You will also be asked optional questions that we collect to improve the quality of service we provide at Covered California.

You may need:

- Citizenship or immigration status information.
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your family.

Estimated time to complete:

- 15 minutes

[Back](#)[Save & Exit](#)[Continue](#)

Learn**See Health Plans****APPLY****Renew**

Josh Smith

Account #: 5372



PERSONAL DATA

 Introduction**Address & Contact**

Demographic Data

Tax Information

Health Care

Optional Data

Summary

PERSONAL DATA - ADDRESS AND CONTACT INFORMATION

Please answer all the required questions for each household member.

▼ Josh Smith

Residence Address

Is this person's residence address same as the household primary contact's address? Yes No

Mailing Address

Is this person's mailing address same as the household primary contact's address? Yes No

Contact Phone and Email

Home Phone

Learn

See Health Plans

APPLY

Renew

Josh Smith

Account #: 5372



PERSONAL DATA

PERSONAL DATA - DEMOGRAPHIC INFORMATION

Please answer all the required questions for each household member

▼ Josh Smith

What is this person's marital status? *

Married



Is this person blind and/or disabled? *

Yes

No

Does this person have a medical expense in the last 3 months? *

Yes

No

Is this person a member of a federally-recognized Indian Tribe? *

Yes

No

Demographic Data

Tax Information

Health Care

Optional Data

Summary

What is this person's marital status? *

Married

Is this person blind and/or disabled? *

Yes No

Does this person have a medical expense in the last 3 months? *

Yes No

Is this person pregnant? *

Yes No

What is the expected date of delivery? *

Number of babies expected? *

1

Is this person a member of a federally-recognized Indian Tribe? *

Yes No

Back

Save & Exit

Continue



Learn

See Health Plans

APPLY

Renew

Josh Smith

Account #: 5372



PERSONAL DATA

✓ Introduction

✓ Address & Contact

✓ Demographic Data

Tax Information

Health Care

Optional Data

Summary


TAX INFORMATION

Please answer all required (*) questions for each household member.

▼ Josh Smith


Is this person the Primary Tax Filer? *  Yes No

Did this person file taxes last year? * Yes No

What was this person's tax filing status last year? * 

Was this person claimed as a dependent on any tax return last year? * Yes No

Is this person planning to file taxes this year? * Yes No

What is this person's expected tax filing status for the benefit year? * 

Is this person expected to be claimed as a dependent on any tax return for the benefit year? * Yes No

Is this person the Primary Tax Filer? * ? Yes No

Did this person file taxes last year? * Yes No

Was this person claimed as a dependent on any tax return last year? * Yes No

Is this person planning to file taxes this year? * Yes No

Is this person expected to be claimed as a dependent on any tax return for the benefit year? * Yes No

Who expects to claim this person as a tax dependent? * ▼

Is this person claimed by a non-custodial parent? * ? Yes No

Is this person expected to be required to file taxes this year? * Yes No

Back

Save & Exit

Continue

Learn**See Health Plans****APPLY****Renew**

Josh Smith

Account #: 5372



PERSONAL DATA

✓ Introduction

✓ Address & Contact

✓ Demographic Data

✓ Tax Information

Health Care



Optional Data

Summary

PERSONAL DATA - HEALTH CARE INFORMATION

Please answer all the required questions for each household member.

▼ Josh Smith

Does this person currently have or been offered other health insurance? None of the Above 

Does this person need help with Long Term Care or Home and Community Based Services (HCBS) Waiver services? *

 Yes No

Does this person receive Medicare benefits?

 Yes No

▼ Jane Smith

Does this person currently have or been offered other health insurance? [?](#)

Employer Sponsored Insurance outside Exchange ▾

What is the name of the Employer? *

What is the enrollment status? *

Select One ▾

How much does the person pay in monthly premiums?

Does the health plan meet the "minimum value standard"? * [?](#)

Yes No

Does this person need help with Long Term Care or Home and Community Based Services (HCBS) Waiver services? *

Yes No

Does this person receive Medicare benefits?

Yes No

Back

Save & Exit

Continue



Learn

See Health Plans

APPLY

Renew

Josh Smith

Account #: 5372



PERSONAL DATA

✓ Introduction

✓ Address & Contact

✓ Demographic Data

✓ Tax Information

✓ Health Care

Optional Data

Summary


PERSONAL DATA - OPTIONAL DATA

Please provide the important additional information below. This is voluntary information collected to improve the quality of the care provided.


▼ Josh Smith

Optional demographic information is collected to improve the quality of service provided by the Healthcare Exchange.

What is the person's preferred written language of communication?


Select One 

What is the person's preferred spoken language of communication?

Select One 

Is this person of Hispanic, Latino, or Spanish origin? 

Yes No

What is this person's race? 
(check all that apply)

- AI/AN
- Asian Indian
- Black or African American
- Chinese
- Filipino
- Guamanian/Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Samoan
- Vietnamese
- White
- Other

Optional demographic information is collected to improve the quality of service provided by the Healthcare Exchange.

What is the person's preferred written language of communication?

What is the person's preferred spoken language of communication?

Is this person of Hispanic, Latino, or Spanish origin? [?](#)

 Yes No

What is this person's race? [?](#)
(check all that apply)

- AI/AN
- Asian Indian
- Black or African American
- Chinese
- Filipino
- Guamanian/Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Samoan
- Vietnamese
- White
- Other

Back

Save & Exit

Continue

Learn

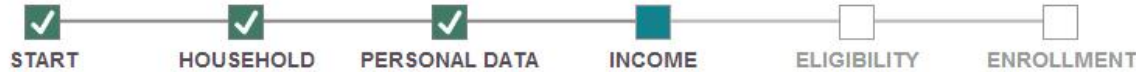
See Health Plans

APPLY

Renew

Josh Smith

Account #: 5372



HOUSEHOLD INCOME

Introduction

Employment Income

Self Employment Inco...

Other Income

Income Deductions

Income Summary



INCOME INTRODUCTION

Coming Up In This Section

In this section, you will be asked about your household income. We will walk you through 4 sections: employment income, self-employment income, other income and income deductions. You can enter information about each type of income for each person in your household. If nobody in your household has a particular type of income, you can skip that step and move to the next type of income. When you have entered all your information, we will show your household income.

You may need:

- Most recent tax filing
- Pay stubs

Estimated time to complete:

- 10 minutes

Back

Save & Exit

Continue

Learn

See Health Plans

APPLY

Renew

Josh Smith

Account #: 5372



START



HOUSEHOLD



PERSONAL DATA



INCOME



ELIGIBILITY



ENROLLMENT

HOUSEHOLD INCOME

✓ Introduction

Employment Income

Self Employment Inco...

Other Income

Income Deductions

Income Summary

EMPLOYMENT INCOME

Total current monthly household income: \$ 0.00

On this page, enter employment income for this month for everyone in your household. Employment income means payments for full-time, part-time or one-time work (before taxes are taken out). To add an income item, click the "Add" button. If no one in the household has any employment income, click the "Continue" button.

| Person | Source of Employment Income | Monthly Amt | Edit | Delete |
|--------|-----------------------------|-------------|------|--------|
|--------|-----------------------------|-------------|------|--------|

Learn**See Health Plans****APPLY****Renew**

Josh Smith

Account #: 5372



START



HOUSEHOLD



PERSONAL DATA



INCOME



ELIGIBILITY



ENROLLMENT

HOUSEHOLD INCOME

✓ Introduction

Employment Income

Self Employment Inco...

Other Income

Income Deductions

Income Summary

Add Employment Income

Household Member Employer Amount(before taxes)(\$)
How Often Days per week

Cancel

OK



Josh Smith
Account #: 5372

HOUSEHOLD INCOME

- ✓ Introduction
- ✓ Employment Income
- Self Employment Income**
- Other Income
- Income Deductions
- Income Summary



SELF EMPLOYMENT INCOME

Total current monthly household income: \$ 833.33

On this page, enter the income that any household member will earn this month from self-employment from his or her regular job, with the taxes taken out.

To add an income item, click Add Income.

| Person | Source of Self-Employment Income | Monthly Amt | Edit | Delete |
|--------|----------------------------------|-------------|------|--------|
|--------|----------------------------------|-------------|------|--------|

Add Income

Back

Save and Exit

Continue

Learn | See Health Plans | **APPLY** | Renew

 Josh Smith
 Account #: 5372

HOUSEHOLD INCOME

- ✓ Introduction
- ✓ Employment Income
- ✓ Self Employment In...

Other Income

Income Deductions

Income Summary

OTHER INCOME i

Total current monthly household income: \$ 833.33

Other income includes any income you have not already entered, such as income from Unemployment Benefits, Social Security, retirement accounts, rents or royalties, alimony, investments, capital gains, and other types of income.

Note: You do not need to tell us about child support, veteran's benefits, or Supplemental Security Income (SSI) income.

To add an income item, click the "Add" button. If no one in the household has any income of these types, click the "Continue" button.

| Person | Source of Other Income | Monthly Amt | Edit | Delete |
|--|------------------------|-------------|------|--------|
| <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #f9f9f9;">Add Income</div> <div style="display: flex; gap: 10px;"> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #f9f9f9;">Back</div> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #f9f9f9;">Save and Exit</div> </div> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #f9f9f9; color: white;">Continue</div> </div> | | | | |

Add Income

Back

Save and Exit

Continue



Josh Smith
Account #: 5372

HOUSEHOLD INCOME

- ✓ Introduction
- ✓ Employment Income
- ✓ Self Employment In...
- ✓ Other Income
- Income Deductions**
- Income Summary



INCOME DEDUCTIONS

Total current monthly household income: \$ 833.33

If a person pays for certain expenses that can be deducted on an income tax return, telling us about these expenses could make the cost of health insurance a little lower. Examples of these expenses include alimony, mortgage interest, or student loan interest. (If you have already included an expense when you calculated your net self-employment or rental property income, do not include it here.)

To add a deduction, click "Add Deduction" .

| Person | Type of Income Deduction | Monthly Amt | Edit | Delete |
|---|--------------------------|-------------|------|--------|
| <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #ccc;">Add Deduction</div> <div style="display: flex; gap: 10px;"> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #ccc;">Back</div> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #ccc;">Save and Exit</div> </div> <div style="border: 1px solid #ccc; padding: 5px 15px; background-color: #ffc107; font-weight: bold;">Continue</div> </div> | | | | |

Learn | See Health Plans | **APPLY** | Renew

 Josh Smith
 Account #: 5372


HOUSEHOLD INCOME

- ✓ Introduction
- ✓ Employment Income
- ✓ Self Employment In...
- ✓ Other Income
- ✓ Income Deductions

Income Summary

INCOME SUMMARY



| <i>Income Type</i> | <i>Amount</i> | |
|--|--------------------|-------------------------------------|
| Employment Income | \$ 833.33 | <input type="button" value="Edit"/> |
| Self Employment Income | \$ 0 | <input type="button" value="Edit"/> |
| Other Income | \$ 0 | <input type="button" value="Edit"/> |
| Subtotal | \$ 833.33 | |
| Deductions | \$ 0 | <input type="button" value="Edit"/> |
| Total Current Monthly Household Income | \$ 833.33 | |
| Total Projected Annual Household Income | \$ 10000.00 | ? |

 Enter the projected annual household income if different from above ?

 | |

Learn

See Health Plans

APPLY

Renew

Josh Smith
Account #: 5372

ELIGIBILITY

Review Application

Application Signature

Eligibility Results

APPLICATION SIGNATURE

Please read the following information and Electronically Sign your application below.

Maintaining your Verification

I understand that the Exchange will use data from my tax return during the renewal process to determine yearly eligibility for help paying for health insurance for the next 5 years. I understand that if I check this box I can change my answer later, and if I don't check the box, I can select less than five years.

Maintain my consent for:

4 Years

I know that I must tell the program I'm enrolled in if information I listed on this application changes.

Review and Sign

I'm signing this application under penalty of perjury. This means I've provided true answers to all the questions on this form to the best of my knowledge. I know that if I'm not truthful, there may be a penalty.

Exchange requires that you certify Eligibility part of your application by submitting an electronic signature (type your fullname) and electronic signature PIN.

Electronic Signature *

Type your full name

Electronic PIN *

Type Your PIN

[Forgot PIN](#)

Back

Save & Exit

Submit

Medi-Cal
Eligibility
Determination Results
Page

Josh Smith
Account #: 5372
Case #: 5372



ELIGIBILITY

Review Application

Application Signature

Eligibility Results

ELIGIBILITY RESULTS

Your eligibility is pending additional information. See details below.

Josh Smith

Medi-Cal: Eligibility Pending

Your application is pending. To receive benefits, you must do the following:

- Verification of California Residency
- Verification of income

[Upload Documents](#)

Not eligible for the following:

- Advance Payment of Premium Tax Credit (APTC)
- Cost Sharing Reduction (CSR)

▼ Important Information & Options**Eligibility Determination Factors**

- California residency must be verified
- Not eligible for APTC
- Household does not fall within eligibility limits for Medi-Cal, CSR, APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Other Medi-Cal Programs

You may be eligible for other Medi-Cal programs that would allow you to get health care services right away. For more information, call 800-XXX-XXXX.

Medi-Cal: Eligibility Pending

Your application is pending. To receive benefits, you must do the following:

- Verification of California Residency
- Verification of income

[Upload Documents](#)

Not eligible for the following:

- Advance Payment of Premium Tax Credit (APTC)
- Cost Sharing Reduction (CSR)

▼ Important Information & Options

Eligibility Determination Factors

- California residency must be verified
- Not eligible for APTC
- Household does not fall within eligibility limits for CSR, APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Other Medi-Cal Programs

You may be eligible for other Medi-Cal programs that would allow you to get health care services right away. For more information, call 800-XXX-XXXX.

Save & Exit

View Submitted Application

View Medi-Cal Details

Mixed Household
Eligibility
Determination Results
Page

Learn

See Health Plans

APPLY

Renew

Josh Smith

Account #: 5393

Case #: 5372

ELIGIBILITY

Review Application

Application Signature

Eligibility Results



ELIGIBILITY RESULTS

Here are your eligibility results - the programs you are eligible for. To view your options and enroll in a health insurance plan, you must click the "Choose a Health Plan" button below.

Josh Smith

Covered California Plan: Eligible

Effective: January 01, 2014

Advance Payment of Premium Tax Credit (APTC): Eligible

Josh Smith: Up to \$1,440.00 for the tax year 2014

Cost Sharing Reduction (CSR): Eligible

You must select a health plan by January 31, 2014. To choose a health plan, click the "Choose a Health Plan" button below.

Not eligible for the following:

- Medi-Cal

▼ Important Information & Options**Eligibility Determination Factors**

- California residency must be verified
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Referral to Other Programs

You may be eligible for other benefit programs. You can send your information to your county social service office as a referral for further action.

[View Other Programs](#)

Covered California Plan: Eligible

Effective: January 01, 2014

Medi-Cal: Eligibility Pending

Your application is pending. To receive benefits, you must do the following:

- Verification of California Residency

[Upload Documents](#)

You must select a health plan by January 31, 2014. To choose a health plan, click the "Choose a Health Plan" button below.

Not eligible for the following:

- Advance Payment of Premium Tax Credit (APTC)
- Cost Sharing Reduction (CSR)

▼ Important Information & Options

Eligibility Determination Factors

- California residency must be verified
- Not eligible for APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Referral to Other Programs

You may be eligible for other benefit programs. You can send your information to your county social service office as a referral for further action.

[View Other Programs](#)

Medi-Cal: Eligibility Pending

Your application is pending. To receive benefits, you must do the following:

- Verification of California Residency

[Upload Documents](#)

You must select a health plan by January 31, 2014. To choose a health plan, click the "Choose a Health Plan" button below.

Not eligible for the following:

- Advance Payment of Premium Tax Credit (APTC)
- Cost Sharing Reduction (CSR)

▼ Important Information & Options

Eligibility Determination Factors

- California residency must be verified
- Not eligible for APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Referral to Other Programs

You may be eligible for other benefit programs. You can send your information to your county social service office as a referral for further action.

[View Other Programs](#)

To complete your enrollment, click on "Choose a Health Plan."

Save & Exit

View Submitted Application

Choose a Health Plan



Mixed Unsubsidized
Eligibility
Determination Results
Page

Learn

See Health Plans

APPLY

Renew

Josh Smith

Account #: 5384

Case #: 5372



ELIGIBILITY

Review Application

Application Signature

Eligibility Results

ELIGIBILITY RESULTS

Your eligibility is pending additional information. See details below.

Josh Smith

Medi-Cal: Eligibility Pending

Your application is pending. To receive benefits, you must do the following:

- Verification of California Residency

[Upload Documents](#)

You must select a health plan by January 31, 2014. To choose a health plan, click the "Choose a Health Plan" button below.

Not eligible for the following:

- Advance Payment of Premium Tax Credit (APTC)
- Cost Sharing Reduction (CSR)

Important Information & Options

Eligibility Determination Factors

- California residency must be verified
- Not eligible for APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Eligibility Determination Factors

- California residency must be verified
- Not eligible for APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Referral to Other Programs

You may be eligible for other benefit programs. You can send your information to your county social service office as a referral for further action.

[View Other Programs](#)

Jane Smith

Covered California Plan: Eligible

Effective: January 01, 2014

Medi-Cal: Eligibility Pending

Your application is pending. To receive benefits, you must do the following:

- Verification of California Residency

[Upload Documents](#)

You must select a health plan by January 31, 2014. To choose a health plan, click the "Choose a Health Plan" button below.

Not eligible for the following:

- Advance Payment of Premium Tax Credit (APTC)
- Cost Sharing Reduction (CSR)

▼ **Important Information & Options**

Eligibility Determination Factors

- California residency must be verified
- Not eligible for APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Referral to Other Programs

You may be eligible for other benefit programs. You can send your information to your county social service office as a referral for further action.

[View Other Programs](#)

Medi-Cal: Eligibility Pending

Your application is pending. To receive benefits, you must do the following:

- Verification of California Residency

[Upload Documents](#)

You must select a health plan by January 31, 2014. To choose a health plan, click the "Choose a Health Plan" button below.

Not eligible for the following:

- Advance Payment of Premium Tax Credit (APTC)
- Cost Sharing Reduction (CSR)

▼ Important Information & Options

Eligibility Determination Factors

- California residency must be verified
- Not eligible for APTC
- All other eligibility determination factors have been met

You will receive additional result details by your preferred method of communication.

Appeal Decision

If you think the decision is incorrect, you can appeal it within 90 days.

[Appeal Decision](#)

Referral to Other Programs

You may be eligible for other benefit programs. You can send your information to your county social service office as a referral for further action.

[View Other Programs](#)

- ENROLLMENT
- Enrollment Introduction**
- Plan Selection
- Enrollment Summary

HOUSEHOLD ENROLLMENT INTRODUCTION i

Members of your household are eligible for the health programs listed below. Each program has a set of available health plans for you to compare. You can choose the health plan that is the best fit for you.

You must choose a health plan before insurance coverage can begin. You have until

To start, click Choose Health plan for one of the programs below. When you finish that program, you will come back to this page to go to the next program.

| Persons | Program | Health Plan | Carrier Website Address |
|---------------------------|-------------------------------------|--|---------------------------|
| Josh Smith | Qualified Health Plan with APTC/CSR | Choose Health Plan | No plan has been selected |
| Jane Smith | Covered California Plan | Choose Health Plan | No plan has been selected |
| Jill Smith Jimmy Smith | Medi-Cal | You will receive information about your Medi-Cal benefits by your preferred communication method | No plan has been selected |

[Back](#) [Save & Exit](#)

[Learn](#)[See Health Plans](#)[APPLY](#)[Renew](#)[✓ Getting Started](#)[2. Browse Plans](#)[3. Checkout](#)

Tell us whats important to you, and well help you compare Health plans

[▼ Estimate Costs](#)[▼ Find Your Doctor or Facility](#)

Do you have a Doctor or Medical Facility that you prefer?

If Yes, add your doctor(s)/ facilities to your provider list. In the next steps you will see which plans support your preferred providers.

[Find Your Doctor](#)[Find Your Facility](#)[Next Plan Selection](#)



Find your Doctor

Name

Near

Search

✓ Getting Started

2. Browse Plans

3. Checkout

Back

1. Carlos Frias

SPECIALITIES:

2750 Loma Vista Rd, CA 93003
8055250215





Back

Search Again

Carlos Frias

2750 Loma Vista Rd, CA 93003

P: 8055250215

Specialities: **YES**

Board Certified:

Languages: ,

Medical School: **California University-CA**



Add to my providers list

Find your Facility

Name

Near

Back

Search Again

ANTELOPE VALLEY HOSPITAL

1600 W Avenue J, CA 93534



Add to my providers list

✓ Getting Started

2. Browse Plans

3. Checkout

Tell us what's important to you, and we'll help you compare Health plans

Estimate Costs

Which category does *each member* of your family best fit into? [Learn More](#)

Medical Use



number of family members

Low

Doctor Visits:
1 - 2 per year
Lab tests:
1 - 2 per year



number of family members

Moderate

Doctor Visits:
5 - 6 per year
Lab tests:
Several per year



number of family members

High

Doctor Visits:
Monthly
Lab tests:
Regular/Ongoing
Other:
Outpatient Care



number of family members

Very High

Doctor Visits:
20+ per year
Lab tests:
Multiple Ongoing
Other:
Hospital Stay
Having a Baby

Which category does each member of your family best fit into? [Learn More](#)

Prescription Use



number of family members

Low

Prescriptions:
1 or less



number of family members

Moderate

Prescriptions:
1 - 2



number of family members

High

Prescription:
2 - 3 (ongoing)



number of family members

Very High

Prescription:
3+ (ongoing)

Find Your Doctor or Facility

Next Plan Selection

[Learn](#)
[See Health Plans](#)
[APPLY](#)
[Renew](#)
[← Back](#)
[✓ Getting Started](#)
[2. Browse Plans](#)
[3. Checkout](#)

3 Plans

Sort By ▾

Filter By ▾

Your Favorites (0)

Print

Your Cart (0)



KP Platinum 0/20

 Your Monthly Premium
\$347

After tax credit of \$39

Add



KP Bronze 5000/30

 Your Monthly Premium
\$181

After tax credit of \$39

Add



KP Bronze HSA 4500/40

 Your Monthly Premium
\$178

After tax credit of \$39

Add

Summary

 Estimated Total Costs
 Premium + OOP
[Customize Now](#)

 \$4664
 per year

 \$2872
 per year

 \$2636
 per year

[Overall Quality](#)

Not Available

Not Available

Not Available

[My Doctors
Search](#)

Search

Search

Search

[My Facilities
Search](#)

Search

Search

Search

[Product Type](#)

HMO

HMO

HMO

[Discounts](#)

Not Available

Not Available

Not Available

▼ Quality Rating

Overall Quality

Not Available

Not Available

Not Available

Access

Not Available

Not Available

Not Available

Staying Healthy

Not Available

Not Available

Not Available

Plan Service Rating

Not Available

Not Available

Not Available

Clinical Care Rating

Not Available

Not Available

Not Available

▼ Deductible & Out-of-Pocket

| | | | |
|---|----------------------------------|----------------------------------|----------------------------------|
| <u>Deductible (Individual)</u> | Not Available | \$5000.0 | \$4500.0 |
| <u>Out-Of-Pocket Maximum (Individual)</u> | \$4000.0 | \$6350.0 | \$6350.0 |
| <u>Deductible (Family)</u> | Not Applicable for single Member | Not Applicable for single Member | Not Applicable for single Member |
| <u>Out-Of-Pocket Maximum (Family)</u> | Not Applicable for single Member | Not Applicable for single Member | Not Applicable for single Member |
| <u>Medical Deductible (Individual)</u> | \$0.0 | Not Available | Not Available |
| <u>Brand Drug Deductible (Individual)</u> | \$0.0 | Not Available | Not Available |
| <u>Medical Out-Of-Pocket Maximum (Individual)</u> | Not Available | Not Available | Not Available |
| <u>Brand Drug Out-Of-Pocket Maximum (Individual)</u> | Not Available | Not Available | Not Available |
| <u>Medical Deductible (Family)</u> | Not Applicable for single Member | Not Applicable for single Member | Not Applicable for single Member |
| <u>Medical Out-Of-Pocket Maximum (Family)</u> | Not Applicable for single Member | Not Applicable for single Member | Not Applicable for single Member |
| <u>Brand Drug Out-Of-Pocket Maximum (Family)</u> | Not Applicable for single Member | Not Applicable for single Member | Not Applicable for single Member |

▼ Doctor Visit

Primary care visit to treat an injury or illness

\$20 Copay

\$60 Copay after deductible

40% Coinsurance after deductible

Specialist visit

\$40 Copay

\$70 Copay before deductible

40% Coinsurance after deductible

Other practitioner office visit

\$20 Copay

\$60 Copay after deductible

40% Coinsurance after deductible

Preventive care/ screening/immunization

Not Available

Not Available

Not Available

▼ Tests

Laboratory Tests

\$20 Copay

30% Coinsurance after deductible

40% Coinsurance after deductible

X-rays and Diagnostic Imaging

\$40 Copay

30% Coinsurance after deductible

40% Coinsurance after deductible

Imaging (CT/PET scans, MRIs)

\$150 Copay

30% Coinsurance after deductible

40% Coinsurance after deductible

▼ Drugs

Generic drugs

\$5 Copay

\$25 Copay after deductible

40% Coinsurance after deductible

Preferred brand drugs

\$15 Copay

\$50 Copay after deductible

40% Coinsurance after deductible

Non-preferred brand drugs

\$15 Copay

\$50 Copay after deductible

40% Coinsurance after deductible

Specialty drugs

\$15 Copay

\$50 Copay after deductible

40% Coinsurance after deductible

▼ Outpatient

Outpatient Facility fee (e.g., ASC)

6% Coinsurance

30% Coinsurance after deductible

40% Coinsurance after deductible

Outpatient Surgery Physician/Surgical Services

Not Available

30% Coinsurance after deductible

40% Coinsurance after deductible

▼ ER & Urgent Care

Emergency room services
(waived if admitted)

\$150 Copay

\$300 Copay after deductible

40% Coinsurance after deductible

Emergency medical transportation

\$150 Copay

\$300 Copay after deductible

40% Coinsurance after deductible

Urgent care

\$40 Copay

\$60 Copay after deductible

40% Coinsurance after deductible

▼ Hospital

Hospital Facility fee

6% Coinsurance

30% Coinsurance after deductible

40% Coinsurance after deductible

Hospital Physician/surgeon fee

Not Available

30% Coinsurance after deductible

40% Coinsurance after deductible

▼ Mental / Behavioral Health

Mental/Behavioral health
outpatient services

\$20 Copay

\$60 Copay after
deductible

40% Coinsurance after
deductible

Mental/Behavioral health
inpatient services

\$250 Copay

30% Coinsurance after
deductible

40% Coinsurance after
deductible

Substance use disorder
outpatient services

\$20 Copay

\$60 Copay after
deductible

40% Coinsurance after
deductible

Substance use disorder
inpatient services

\$250 Copay

30% Coinsurance after
deductible

40% Coinsurance after
deductible

▼ Pregnancy

Prenatal and postnatal
care

Not Available

Not Available

Not Available

Delivery and all inpatient
services - Hospital Fees

\$250 Copay per Day

\$0 Copay per Day

\$0 Copay per Day

Delivery and all inpatient
services - Professional
Fees

Not Available

30% Coinsurance after
deductible

40% Coinsurance after
deductible

30% Coinsurance after
deductible

40% Coinsurance after
deductible

▼ Other Special Needs

| | | | |
|----------------------------------|---------------------|---|---|
| <u>Home health care</u> | Not Available | Not Available | Not Available |
| <u>Rehabilitation services</u> | \$20 Copay | 30% Coinsurance after deductible | 40% Coinsurance after deductible |
| <u>Habilitation services</u> | \$20 Copay | 30% Coinsurance after deductible | 40% Coinsurance after deductible |
| <u>Skilled nursing care</u> | \$150 Copay per Day | \$0 Copay per Day 30% Coinsurance after deductible | \$0 Copay per Day 40% Coinsurance after deductible |
| <u>Durable medical equipment</u> | 10% Coinsurance | 30% Coinsurance after deductible | 40% Coinsurance after deductible |
| <u>Hospice service</u> | Not Available | Not Available | Not Available |

▼ Children's Vision

| | | | |
|-----------------|---------------|---------------|---------------|
| <u>Eye exam</u> | Not Available | Not Available | Not Available |
| <u>Glasses</u> | Not Available | Not Available | Not Available |

← Back

Checkout

1. Cart

2. Provide eSignature

3. Confirmation

Your Cart

Health Plans

Matt

| | | | | |
|---|------------------------------|--------------------------------------|------------------------|--------------------------|
|  | kaiser2 KP Bronze 5000/30 | Monthly Premium Tax Credit (APTC) | \$220.00 -\$39 / mo | <input type="checkbox"/> |
|---|------------------------------|--------------------------------------|------------------------|--------------------------|

Your Payment

\$181.00/mo

Total Monthly Premiums

\$220

Monthly Tax Credit (APTC)

-\$39

Cart Total

Your Payment

\$181/mo

← Back

Checkout

1. Cart

2. Provide eSignature

3. Confirmation

Tax Credit



Matt qualifies for a tax credit of \$39.0 for purchasing health insurance.

You qualify for a tax credit for purchasing health insurance effectively lowering the cost of your insurance. You have a choice of how you want to receive your credit:

- Receive a portion of your tax credit every month throughout the year to help pay your insurance premiums
- Receive your entire tax credit all at once after you file your 2014 tax return next April

Here's more information about your tax credit.

The amount shown here is an estimate based on the estimate of your 2014 income you made when you began the enrollment process. The actual credit depends on the income you declare in your 2014 tax return. If your actual income on your tax return is higher than your estimate, you could have to return some or all of the amount you received if you took a portion of the credit each month throughout the year. To receive the annual tax credit, you are required to file a federal tax return for 2014.

1

2

3

Close

Confirm

\$220.00
-\$39 / mo

\$181.00/mo

Premiums \$220

Adjust -\$39

Payment \$181/mo

Continue Shopping

Checkout

← Back

Checkout

1. Cart

2. Provide eSignature

3. Confirmation

Tax Credit

×

Monthly Advance

You can choose to use some or all of your premium tax credit in advance of filing your tax return to lower your monthly premium.

Pros: Your insurance costs less each month.

Cons: If your income increases, you could owe money at tax time.

Annual Credit

You can claim the premium tax credit on your annual federal tax return to lower the tax you owe or increase your refund.

Pros: No risk of having to repay at tax time.

Cons: You pay more for insurance each month.

1

2

3

Close

Confirm

\$220.00

-\$39 / mo

\$181.00/mo

Premiums \$220

Adjust -\$39

Final Payment \$181/mo

Continue Shopping

Checkout

← Back

Checkout

1. Cart

2. Provide eSignature

3. Confirmation

Tax Credit

×

Move the slider to determine how you receive your credit

Monthly Tax Credit

\$ 39.0 / mo

Annual Tax Credit

\$ 0.0

Remember that if your actual household income for [2014] is more than you estimated, you may have to repay some or all of the monthly advance. You will be able to change how you receive your credit when you choose your health plan.

1

2

3

Close

Confirm

\$220.00

-\$39 / mo

\$181.00/mo

Premiums \$220

Adjust -\$39

Payment \$181/mo

Continue Shopping

Checkout

[← Back](#)

✓ Getting Started

2. Browse Plans

3. Checkout

Plan Details

Logo kaiser2 KP Platinum 0/20

| | |
|-----------------------------|--------------|
| Monthly Premium | \$386 |
| Tax Credit | -\$39.0 |
| Your Monthly Premium | \$347 |

| | |
|----------------------------|------------------------|
| Your Annual Premium | \$4164 per year |
| Out-of-Pocket Estimate | \$500 |
| Product Type | HMO |
| Overall Quality | Not Available |
| Children's Dental Included | No |

[Download Summary of Benefits and Coverage](#)

[Print](#) [Add to Cart](#)

| Summary | |
|---|------------------------|
| Estimated Total Costs Premium + OOP | 4164.0 |
| Overall Quality | Not Available |
| My Doctors | Search |
| My Facilities | Search |
| My Dentists | Search |
| Product Type | HMO |
| Discounts | |

| Quality Ratings | |
|----------------------|---------------|
| Overall Quality | Not Available |
| Access | Not Available |
| Staying Healthy | Not Available |
| Plan Service Rating | Not Available |
| Clinical Care Rating | Not Available |

| Deductible & Out-of-Pocket | In Network |
|--|----------------------------------|
| Deductible (Individual) | Not Available |
| Out-Of-Pocket Maximum (Individual) | \$4000.0 |
| Deductible (Family) | Not Applicable for single Member |
| Medical Deductible (Individual) | Not Applicable for single Member |
| Brand Drug Deductible (Individual) | Not Applicable for single Member |
| Medical Out-Of-Pocket Maximum (Individual) | \$0.0 |
| Brand Drug Out-Of-Pocket Maximum (Individual) | \$0.0 |
| Medical Deductible (Family) | Not Applicable for single Member |
| Brand Drug Deductible (Family) | Not Applicable for single Member |
| Medical Out-Of-Pocket Maximum (Family) | |
| Brand Drug Out-Of-Pocket Maximum (Family) | |

| Doctor Visit | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|---|---------------|-----------------------|----------------|----------------|
| <u>Primary care visit to treat an injury or illness</u> | \$20 Copay | ☐ | Not Available | Not Available |
| <u>Specialist visit</u> | \$40 Copay | ☐ | Not Available | Not Available |
| <u>Other practitioner office visit</u> | \$20 Copay | ☐ | Not Available | Not Available |
| <u>Preventive care/ screening/immunization</u> | Not Available | ☐ | Not Available | Not Available |

| Tests | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|-------------------------------|-------------|-----------------------|----------------|----------------|
| Laboratory Tests | \$20 Copay | ☐ | Not Available | Not Available |
| X-rays and Diagnostic Imaging | \$40 Copay | ☐ | Not Available | Not Available |
| Imaging (CT/PET scans, MRIs) | \$150 Copay | ☐ | Not Available | Not Available |

| Drugs | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|---------------------------|------------|-----------------------|----------------|----------------|
| Generic drugs | \$5 Copay | ☐ | Not Available | Not Available |
| Preferred brand drugs | \$15 Copay | ☐ | Not Available | Not Available |
| Non-preferred brand drugs | \$15 Copay | ☐ | Not Available | Not Available |
| Specialty drugs | \$15 Copay | ☐ | Not Available | Not Available |

| Outpatient | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|--|----------------|-----------------------|----------------|----------------|
| Outpatient Facility fee (e.g., ASC) | 6% Coinsurance | ☐ | Not Available | Not Available |
| Outpatient Surgery Physician/Surgical Services | Not Available | ☐ | Not Available | Not Available |

| ER & Urgent care | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|--|-------------|-----------------------|----------------|----------------|
| Emergency room services (waived if admitted) | \$150 Copay | ☐ | Not Available | Not Available |
| Emergency medical transportation | \$150 Copay | ☐ | Not Available | Not Available |
| Urgent care | \$40 Copay | ☐ | Not Available | Not Available |

| Hospital | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|---------------------------------------|----------------|-----------------------|----------------|----------------|
| <u>Hospital Facility fee</u> | 6% Coinsurance | ☐ | Not Available | Not Available |
| <u>Hospital Physician/surgeon fee</u> | Not Available | ☐ | Not Available | Not Available |

| Mental / Behavioral Health | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|---|-------------|-----------------------|----------------|----------------|
| <u>Mental/Behavioral health outpatient services</u> | \$20 Copay | ☐ | Not Available | Not Available |
| <u>Mental/Behavioral health inpatient services</u> | \$250 Copay | ☐ | Not Available | Not Available |
| <u>Substance use disorder outpatient services</u> | \$20 Copay | ☐ | Not Available | Not Available |
| <u>Substance use disorder inpatient services</u> | \$250 Copay | ☐ | Not Available | Not Available |

| Pregnancy | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|--|---------------------|-----------------------|----------------|----------------|
| <u>Prenatal and postnatal care</u> | Not Available | ☐ | Not Available | Not Available |
| <u>Delivery and all inpatient services - Hospital Fees</u> | \$250 Copay per Day | ☐ | Not Available | Not Available |
| <u>Delivery and all inpatient services - Professional Fees</u> | Not Available | ☐ | Not Available | Not Available |

| Other Special Needs | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|----------------------------------|---------------------|-----------------------|----------------|----------------|
| <u>Home health care</u> | Not Available | ☐ | Not Available | Not Available |
| <u>Rehabilitation services</u> | \$20 Copay | ☐ | Not Available | Not Available |
| <u>Habilitation services</u> | \$20 Copay | ☐ | Not Available | Not Available |
| <u>Skilled nursing care</u> | \$150 Copay per Day | ☐ | Not Available | Not Available |
| <u>Durable medical equipment</u> | 10% Coinsurance | ☐ | Not Available | Not Available |
| <u>Hospice service</u> | Not Available | ☐ | Not Available | Not Available |

| Children's Vision | In Network | Applies to Deductible | Tier 2 Network | Out-of-Network |
|-------------------|---------------|-----------------------|----------------|----------------|
| <u>Eye exam</u> | Not Available | ☐ | Not Available | Not Available |
| <u>Glasses</u> | Not Available | ☐ | Not Available | Not Available |

Checkout


✓ [Cart](#)**2. Provide eSignature**

3. Confirmation

Provide eSignature

To complete the checkout process, read the agreement here and enter your personal identification number (PIN) and eSignature in the spaces below. Entering your PIN and eSignature means that you are sure about the plans you selected and that you have read all terms and conditions.

Exchange Agreement

 Print

I understand that I am required to submit changes that affect my eligibility, including income, dependency changes, address, and incarceration. These changes could affect the plans I can be enrolled. I cannot change plans unless I have a life triggering event. Click here for a list of life triggering events. In addition, I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were

- I have read and agreed to the terms of service in Exchange Agreement.
- I agree to file a [2014] tax return before [April 15, 2015] to claim the Premium Tax Credit.

PIN Number * 

To provide your eSignature please enter your full name. *

Provide eSignature: _____

Date: 08/26/2013

[Back](#)[Enroll](#)

Submit Verification

Learn

See Health Plans

APPLY

Renew

VERIFICATIONS

Manage Verification

Submit Verification

SUBMIT VERIFICATION



You can use this page to submit electronic copy of the required verification documents in order to ensure eligibility. [Click here](#) to know the contact address if in case you would like to submit the verification documents in person or by mail. Please submit all required verification documents within 30 days.

Household Information

Name Josh
Cell Phone Number
Email
Mailing Address 123 Main St. Los Angeles Los Angeles CA 90606
Preferred Communication Email

Required Documents for Josh Smith

| Documents Category | Allowable Document(s) | Uploaded Document(s) | Upload | Status |
|-------------------------------|--|----------------------|------------------------|---------|
| Proof of California Residency | <ul style="list-style-type: none"> Current California driver's license or identification card Current California rent or mortgage receipt in the applicant's name Current California utility bill in the applicant's name Current and valid California vehicle registration form in the applicant's name Evidence that the applicant has enrolled his/her children in a California school Evidence that the applicant is receiving public assistance in California Evidence the applicant has registered with a public or private employment agency in California Evidence the applicant is employed in California Other documents to support Proof of California Residency Voter registration form of receipt, voter notification card, or an abstract of Voter of registration | None | Upload | Pending |

Proof of Immigration Status

- A refugee admitted to the U.S. under Section 207 of the INA
- Approved INS form I-130
- Current I-551 stamp on a foreign passport with codes CU6 or CU7
- Current military orders Letter from the Canadian Department of Indian Affairs
- Current temporary I-551 stamp in a foreign passport with the code AM1, AM2, AM3
- DD form 214
- INCourt order establishing the alien's status
- INS Form I-181 Memorandum of Creation of Record of Lawful Permanent Residence
- INS Form I-220
- INS Form I-488
- INS form 360 petition filed under the Violence Against Women Act (VAWA)
- INS form I-551 with the codes CU6, CU7, or CH6
- INS Form I-220
- INS Form I-488
- INS form 360 petition filed under the Violence Against Women Act (VAWA)
- INS form I-551 with the codes CU6, CU7, or CH6
- INS form I-776 with the code "05"
- INS form I-776 with the code "A10"
- INS form I-797 indicating filing of the I-360 petition
- Ibirth or baptismal record issued on a Canadian Indian Reservation INS form I-551 with the code AM6, AM7, or AM8
- Individual Fee Register receipt, INS Form G-771 and an Interview Appointment Letter

None

[Upload](#)

Pending

Report A Change

Learn

See Health Plans

APPLY

Renew

WELCOME, JOSH

Are you moving? Changing jobs? Expecting a child? We'll keep you covered.

[Report a Change](#)

YOUR APPLICATION IS COMPLETE

You can view the Summary of your Enrollment by clicking on the progress bar below

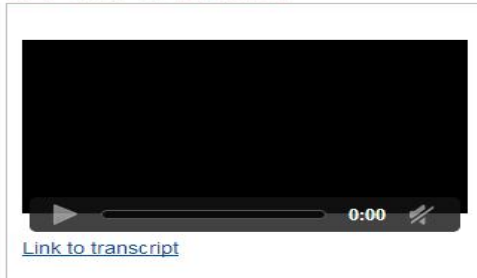


ANNOUNCEMENTS

New Self approval account creation 08/02/2013
text

[View all Announcements](#)

REPORT A CHANGE



Watch the video tutorial on how to tell us about changes that may affect your health coverage, or click [Report a Change](#)

ACTIONS

- [Report a Change](#)
- Continue Change Report
- Withdraw Change Report
- Select Health / Dental Plan
- [Terminate Participation](#)
- Request Exemption
- Submit/Manage Appeal
- [Manage Verifications](#)

RESOURCES

- [Manage Delegates](#)
- [Get Adobe PDF Reader](#)

MORE OPTIONS

- [Register to vote](#)

STAYING COVERED

Covered California can help you find - and keep - health insurance that's right for you at right price you can be comfortable with. If you have a life-changing event such as loss of a job, death of a spouse or birth of a child, you are eligible for special enrollment within 60 days of the event.