California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)

Online Single Streamlined Application
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.

Covered California can help!

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

EMPLOYER
Learn more about health care plans for your employees.

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

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.
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.

<table>
<thead>
<tr>
<th>Questions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your Zip code? *</td>
<td></td>
</tr>
<tr>
<td>What is your total household income per year? *</td>
<td>$</td>
</tr>
<tr>
<td>How many people are in your household? *</td>
<td></td>
</tr>
<tr>
<td>Age of Head of Household *</td>
<td></td>
</tr>
<tr>
<td>Is anyone in your household pregnant? *</td>
<td>Yes</td>
</tr>
<tr>
<td>Is anyone in your household blind or disabled? *</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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:
  - [ ] Pregnant
  - [ ] Blind or Disabled

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

**Available Programs**

<table>
<thead>
<tr>
<th>You May Qualify for:</th>
<th>Access for Infants and Mothers (AIM)</th>
<th>You May Qualify for:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Free or Low-Cost Coverage</strong></td>
<td>Through Medi-Cal</td>
<td><strong>Discounts</strong></td>
</tr>
<tr>
<td></td>
<td>[Fact Sheet]</td>
<td>On health plans offered through Covered California</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>You May Qualify for:</th>
<th>Negotiated Prices</th>
</tr>
</thead>
<tbody>
<tr>
<td>On health plans offered through Covered California</td>
<td>[Fact Sheet]</td>
</tr>
</tbody>
</table>

You must apply so we can find exactly what benefits you qualify for.
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
ACCOUNT TERMS AND CONDITIONS OF USE

Welcome to the Covered California portal. If you use 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
SET UP AN ACCOUNT - YOUR INFORMATION

* Indicates a required field.

- **First Name**
- **Last Name**
- **Date of Birth**
- **Social Security Number**
- **Preferred method of communication**

---

**Buttons:**
- Back
- Continue
CREATE ACCOUNT - CONTACT INFORMATION

* Indicates a required field.

Street Address 1

Street Address 2

City

State  

Zip Code

* Email  username@example.com

Phone Number  XXX-XXX-XXXX

Back

Continue
Confirm Your Mailing Address

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

The address you entered

1. 123 Main St.,
   Los Angeles,
   CA,
   90606

Possible Address 1

1. .
   .
   CA,
   CA,
   90606

Possible Address 1

1. .
   .
   CA,
   CA,
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
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

View Video Transcript

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.
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.
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 up to $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?  

Select One

How did you hear about the Exchange?  

Select One
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]
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
Primary Contact - Name

- First Name: Josh
- Last Name: Smith
- Home Phone Number:
- Work Phone Number:
- Ext.: 
- Cell Phone Number:
- Email: josh.smith@mail.com
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]
HOUSEHOLD MEMBERS

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

- **First Name**: Josh
- **Middle Name**: 
- **Last Name**: Smith
- **Suffix**
- **Is this person applying for health coverage at this time?**
  - Yes
  - No
- **Gender**
  - Select One
- **Date of Birth**
- **Does this person have a Social Security Number?**
  - Yes
  - No
- **Social Security Number**
- **Is this person a U.S. citizen or U.S. national?**
  - Yes
  - No

Add Member  Remove Member
HOUSEHOLD MEMBERS

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

First Name *: Jane
Middle Name:
Last Name *: Smith
Suffix: Select One

Is this person applying for health coverage at this time? *
- Yes
- No

Gender *: Female

Date of Birth *: 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**
- [Redacted]

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

**Is this person a Naturalized citizen?**
- Yes
- No
FAMILY RELATIONSHIPS

Tell us how your household members are related:

<table>
<thead>
<tr>
<th>This person</th>
<th>Is...</th>
<th>to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josh Smith</td>
<td>Select One</td>
<td>Jane Smith</td>
</tr>
</tbody>
</table>

Back | Save & Exit | Continue
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
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
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
Jane 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 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
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? *
    - [Select One]

  - 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? *
    - [Select One]

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

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? *
- Josh Smith

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

Back  Save & Exit  Continue
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
**EMPLOYMENT INCOME**

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.

<table>
<thead>
<tr>
<th>Person</th>
<th>Source of Employment Income</th>
<th>Monthly Amt</th>
<th>Edit</th>
<th>Delete</th>
</tr>
</thead>
</table>

**Add Income**

**Back**  **Save and Exit**

Total current monthly household income: $ 0.00
Add Employment Income

- Household Member: Josh Smith
- Employer: [blank]
- Amount (before taxes): [blank]
- How Often: Daily
- Days per week: [blank]

Buttons: Cancel, OK
### 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.

<table>
<thead>
<tr>
<th>Person</th>
<th>Source of Self-Employment Income</th>
<th>Monthly Amt</th>
<th>Edit</th>
<th>Delete</th>
</tr>
</thead>
</table>

**Add Income**

[Continue]
**OTHER INCOME**

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.

<table>
<thead>
<tr>
<th>Person</th>
<th>Source of Other Income</th>
<th>Monthly Amt</th>
<th>Edit</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Add Income**

**Back**  **Save and Exit**  **Continue**
**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".
## Income Summary

<table>
<thead>
<tr>
<th>Income Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Income</td>
<td>$833.33</td>
</tr>
<tr>
<td>Self Employment Income</td>
<td>$0</td>
</tr>
<tr>
<td>Other Income</td>
<td>$0</td>
</tr>
</tbody>
</table>

**Subtotal**

$833.33

**Deductions**

$0

**Total Current Monthly Household Income**

$833.33

**Total Projected Annual Household Income**

$10000.00

Enter the projected annual household income if different from above.
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
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.

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
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
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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.

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.

To complete your enrollment, click on "Choose a Health Plan"
Mixed Unsubsidized Eligibility Determination Results Page
## 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](#)
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](#)
**HOUSEHOLD ENROLLMENT INTRODUCTION**

 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.

<table>
<thead>
<tr>
<th>Persons</th>
<th>Program</th>
<th>Health Plan</th>
<th>Carrier Website Address</th>
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</thead>
<tbody>
<tr>
<td>Josh Smith</td>
<td>Qualified Health Plan with APTC/CSR</td>
<td>Choose Health Plan</td>
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<tr>
<td>Jane Smith</td>
<td>Covered California Plan</td>
<td>Choose Health Plan</td>
<td>No plan has been selected</td>
</tr>
<tr>
<td>Jill Smith</td>
<td>Medi-Cal</td>
<td>You will receive information about your</td>
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<tr>
<td>Jimmy Smith</td>
<td></td>
<td>Medi-Cal benefits by your preferred</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>communication method</td>
<td></td>
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</tbody>
</table>
Tell us what's important to you, and we'll help you compare Health plans.

2. Browse 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: Type your doctor's name

Near: Type city or zipcode

Search
1. Carlos Frias
SPECIALITIES:
2750 Loma Vista Rd, CA 93003
8055250215
Carlos Frias
2750 Loma Vista Rd. CA 93003
P: 8055250215

Specialties: YES
Board Certified: 

Languages: 
Medical School: California University-CA

Add to my providers list
Find your Facility

Name: Type your facility's name

Near: Type city or zipcode

Search
ANTELOPE VALLEY HOSPITAL
1600 W Avenue J, CA 93534
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**

- **Low**: Doctor Visits: 1 - 2 per year, Lab tests: 1 - 2 per year
- **Moderate**: Doctor Visits: 5 - 6 per year, Lab tests: Several per year
- **High**: Doctor Visits: >20 per year, Lab tests: Regular/Ongoing, Other: Outpatient Care
- **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**

- **Low**: Prescriptions: 1 or less
- **Moderate**: Prescriptions: 1 - 2
- **High**: Prescriptions: 2 - 3 (ongoing)
- **Very High**: Prescriptions: >3 (ongoing)

**Find Your Doctor or Facility**

Next Plan Selection
<table>
<thead>
<tr>
<th>Quality Rating</th>
<th></th>
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<td>Access</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
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<tr>
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<td>Not Available</td>
<td>Not Available</td>
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<td>Plan Service Rating</td>
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<td>Not Available</td>
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<td>Clinical Care Rating</td>
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<td>Not Available</td>
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<td>Out-Of-Pocket Maximum (Individual)</td>
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<td>Not Applicable for single Member</td>
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<td>Not Applicable for single Member</td>
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<td>Doctor Visit</td>
<td>$20 Copay</td>
<td>$60 Copay after deductible</td>
<td>40% Coinsurance after deductible</td>
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<tr>
<td>Primary care visit to treat an injury or illness</td>
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<td>Specialist visit</td>
<td>$40 Copay</td>
<td>$70 Copay before deductible</td>
<td>40% Coinsurance after deductible</td>
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<td>Other practitioner office visit</td>
<td>$20 Copay</td>
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<td>40% Coinsurance after deductible</td>
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<td>Preventive care/screening/immunization</td>
<td>Not Available</td>
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<tr>
<td>X-rays and Diagnostic Imaging</td>
<td>$40 Copay</td>
<td>30% Coinsurance after deductible</td>
<td>40% Coinsurance after deductible</td>
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<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
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### Drugs

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<td>Non-preferred brand drugs</td>
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<tr>
<td>Specialty drugs</td>
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### Outpatient

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<td>Outpatient Facility fees (e.g., ASC)</td>
<td>6%</td>
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<tr>
<td>Outpatient Surgery</td>
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</tr>
<tr>
<td>Physician/Surgical Services</td>
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## ER & Urgent Care

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<th>Copay</th>
<th>After Deductible</th>
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</thead>
<tbody>
<tr>
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<td>$150</td>
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<td>40%</td>
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<tr>
<td>Emergency medical transportation</td>
<td>$150</td>
<td>$300</td>
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<td>Urgent care</td>
<td>$40</td>
<td>$60</td>
<td>40%</td>
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## Hospital

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<th>After Deductible</th>
<th>Coinsurance after Deductible</th>
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<td>6%</td>
<td>30%</td>
<td>40%</td>
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<tr>
<td>Hospital Physician/surgeon fee</td>
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### Mental / Behavioral Health

<table>
<thead>
<tr>
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<th>Coinsurance after deductible</th>
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</thead>
<tbody>
<tr>
<td>Mental/Behavioral health outpatient services</td>
<td>$20 Copay</td>
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<td>Mental/Behavioral health inpatient services</td>
<td>$250 Copay</td>
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<tr>
<td>Substance use disorder outpatient services</td>
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<tr>
<td>Substance use disorder inpatient services</td>
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### Pregnancy

<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Prenatal and postnatal care</td>
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<tr>
<td>Delivery and all inpatient services - Hospital Fees</td>
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<td>Delivery and all inpatient services - Professional Fees</td>
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<tr>
<td>Service</td>
<td>Home Health Care</td>
<td>Rehabilitation Services</td>
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<tr>
<td>------------------------------</td>
<td>------------------</td>
<td>-------------------------</td>
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<tr>
<td>Other Special Needs</td>
<td>Not Available</td>
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<td></td>
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<table>
<thead>
<tr>
<th>Service</th>
<th>Eye Exam</th>
<th>Glasses</th>
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</thead>
<tbody>
<tr>
<td>Children's Vision</td>
<td>Not Available</td>
<td>Not Available</td>
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</table>
Your Cart

1. Cart

Health Plans

Matt

- Kaiser2
- KP Bronze 5000/30

Monthly Premium: $220.00
Tax Credit (APTC): - $39 / mo

Your Payment: $181.00 / mo

Total Monthly Premiums: $220

Monthly Tax Credit (APTC): - $39

Cart Total: $181 / mo

Continue Shopping

Checkout
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.
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.
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.
## 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

### Summary

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<td>My Doctors</td>
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<td>My Facilities</td>
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<tr>
<td>My Dentists</td>
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<td>Product Type</td>
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<td>Quality Ratings</td>
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<tr>
<td>Overall Quality</td>
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<td>Access</td>
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<td>Clinical Care Rating</td>
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<th>Deductible &amp; Out-of-Pocket</th>
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<tr>
<td>Out-Of-Pocket Maximum (Individual)</td>
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<td>Other practitioner office visit</td>
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<td>Preventive care/screening/immunization</td>
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<td>Laboratory Tests</td>
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<td>X-rays and Diagnostic Imaging</td>
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<tr>
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<tr>
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<tr>
<td>Emergency room services (waived if admitted)</td>
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<td>Emergency medical transportation</td>
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<tr>
<td>Hospital Physician/surgeon fee</td>
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<tr>
<td>Mental/Behavioral health outpatient services</td>
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<td>Mental/Behavioral health inpatient services</td>
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<tr>
<td>Substance use disorder outpatient services</td>
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<tr>
<td>Substance use disorder inpatient services</td>
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<td>Delivery and all inpatient services - Hospital Fees</td>
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</tr>
<tr>
<td>Delivery and all inpatient services - Professional Fees</td>
<td>Not Available</td>
<td>=</td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Other Special Needs</td>
<td>In Network</td>
<td>Applies to Deductible</td>
<td>Tier 2 Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------</td>
<td>-----------------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Home health care</td>
<td>Not Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$20 Copay</td>
<td></td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$20 Copay</td>
<td></td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>$150 Copay per Day</td>
<td></td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% Coinsurance</td>
<td></td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>Hospice service</td>
<td>Not Available</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Children’s Vision</th>
<th>In Network</th>
<th>Applies to Deductible</th>
<th>Tier 2 Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Not Available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Available</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

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

[Enroll]
Submit Verification
SUBMIT VERIFICATION

You can use this page to submit electronic copy of the required verification documents inorder 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.

<table>
<thead>
<tr>
<th>Household Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Josh</td>
</tr>
<tr>
<td>Cell Phone Number</td>
</tr>
<tr>
<td>Email</td>
</tr>
<tr>
<td>Mailing Address</td>
</tr>
<tr>
<td>123 Main St. Los Angeles Los Angeles CA 90605</td>
</tr>
<tr>
<td>Preferred Communication</td>
</tr>
<tr>
<td>Email</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Documents for Josh Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Documents Category</strong></td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
</tbody>
</table>
| Proof of California Residency | - 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 |
<table>
<thead>
<tr>
<th>Proof of Immigration Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A refugee admitted to the U.S. under Section 207 of the INA</td>
</tr>
<tr>
<td>• Approved INS form I-130</td>
</tr>
<tr>
<td>• Current I-551 stamp on a foreign passport with codes CU6 or CU7</td>
</tr>
<tr>
<td>• Current military orders Letter from the Canadian Department of Indian Affairs</td>
</tr>
<tr>
<td>• Current temporary I-551 stamp in a foreign passport with the code AM1, AM2, AM3</td>
</tr>
<tr>
<td>• DD form 214</td>
</tr>
<tr>
<td>• INCourt order establishing the alien's status</td>
</tr>
<tr>
<td>• INS Form I-181 Memorandum of Creation of Record of Lawful Permanent Residence</td>
</tr>
<tr>
<td>• INS Form I-220</td>
</tr>
<tr>
<td>• INS Form I-488</td>
</tr>
<tr>
<td>• INS form 360 petition filed under the Violence Against Women Act (VAWA)</td>
</tr>
<tr>
<td>• INS form I-551 with the codes CU6, CU7, or CH6</td>
</tr>
<tr>
<td>• INS Form I-220</td>
</tr>
<tr>
<td>• INS Form I-488</td>
</tr>
<tr>
<td>• INS form 360 petition filed under the Violence Against Women Act (VAWA)</td>
</tr>
<tr>
<td>• INS form I-551 with the codes CU6, CU7, or CH6</td>
</tr>
<tr>
<td>• INS form I-776 with the code &quot;05&quot;</td>
</tr>
<tr>
<td>• INS form I-776 with the code &quot;A10&quot;</td>
</tr>
<tr>
<td>• INS form I-797 indicating filing of the I-360 petition</td>
</tr>
<tr>
<td>• Individual Fee Register receipt, INS Form G-771 and an Interview Appointment Letter</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pending</td>
</tr>
</tbody>
</table>
Report A Change
WELCOME, JOSH
Are you moving? Changing jobs? Expecting a child? We’ll keep you covered.

REPORT A CHANGE

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.