Covered California 2020 2021 Patient-Centered Benefit Plan Designs¹

Final Board-approved Proposed May 16, 2019 January 9, 2020

¹ These are the Standard Benefit Plan Designs pursuant to Government Code Section 100504(c).





ember Cost Share amounts describe the Enrollee's out of pocket costs.		Individual-only Platinum Coinsurance Plan		Individual-only Platinum Copay Plan	
ctuarial Value - A	V Calculator	91.7 <u>91.6%</u>	<u>6</u>	89.1 <u>89.3</u> %	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Individual Out–of–pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
Haalth aara	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's office or clinic visit	Other practitioner office visit	\$15		\$15	
	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
. 30.0					
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Drugs to treat illness or condition	Tier 2	\$15		\$15	
	Tior 2	¢or		¢o.e	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	·		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
Help recovering or		·		\$15 \$150 per day up to	
other special health needs	Skilled nursing care	10%		5 days	
nearn needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
omia eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental				See 2020 2021	
Basic	Restorative Procedures	20%		Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2020 2021	
Major Services	Periodontics (other than maintenance)	50%		Dental Copay Schedule	
OCI VICES	Prosthodontics			Scriedule	
	Oral Surgery				

20202021 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 16, 2019 January 9, 2020

Date: May 16, 2019 January 9, 2020							
Summary of Be	nefits and Coverage	CCSB-on		CCSB-on			
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance		Platinum Copay Pla			
Actuarial Value - A	V Calculator	91.7% 90.6	<u>%</u>	89.1% 88.1	<u>%</u>		
	Plan design includes a deductible?	No		No			
	Integrated Individual deductible	\$0		\$0			
	Integrated Family deductible	\$0		\$0			
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$250 / \$0	/ \$0	\$0 / \$0 / \$	0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$500</u> / \$0 / \$0		\$0 / \$0 / \$	0		
	Individual Out-of-pocket maximum	\$4,500		\$4,500 <u>\$4,0</u>	<u>00</u>		
	Family Out-of-pocket maximum	\$9,000		\$9,000 <u>\$8.0</u>	<u>00</u>		
	HSA plan: Self-only coverage deductible	N/A		N/A			
	HSA family plan: Individual deductible	N/A		N/A			
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies		
	Primary care visit to treat an injury, illness, or condition	\$15		\$15 <u>\$20</u>			
Health care provider's office or clinic	Other practitioner office visit	\$15		\$15 <u>\$20</u>			
office or clinic visit	Specialist visit	\$30		\$30			
VISIL							
	Preventive care/ screening/ immunization	No charge		No charge			
-	Laboratory Tests	\$15		\$15 <u>\$20</u>			
Tests	X-rays and Diagnostic Imaging	\$30		\$30 <u>\$40</u>			
	Imaging (CT/PET scans, MRIs)	10%	X	\$75 <u>\$150</u>			
	Tier 1	\$5		\$5			
Drugs to treat	Tier 2	\$15 <u>\$30</u>		\$15			
illness or condition	Tier 3	\$25 <u>\$50</u>		\$25			
	Tier 4	10% up to \$250 per script		10% up to \$250 per script			
Outpatient services	Surgery facility fee (e.g., ASC)	10%	<u>×</u>	\$100			
	Physician/surgeon fees	10%		\$25			
	Outpatient visit	10%		10%			
	Emergency room facility fee (waived if admitted)	\$150 10%	<u>x</u>	\$ 150 \$250			
Need	Emergency room physician fee (waived if admitted)	No charge	_	No charge			
immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150			
attention		·					
	Urgent care	\$15		\$15 <u>\$20</u>			
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	10%	<u>X</u> <u>X</u>	\$250 per day up to 5 days No charge			
Marchall brooks	Mental/behavioral health and substance use disorder outpatient office		_				
Mental health, behavioral health, or	visits	\$15		\$15 <u>\$20</u>			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15 <u>\$20</u>			
Pregnancy	Prenatal care and preconception visits	No charge		No charge			
	Home health care (cost share per visit)	10%		\$20			
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15 <u>\$20</u>			
recovering or other special	Skilled nursing care	10%	<u>x</u>	\$150 per day up to			
health needs	Durable medical equipment	10%	_	5 days 10%			
	• •						
	Hospice service	No charge		No charge			
Child eye care	Eye exam	No charge		No charge			
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge			
	Oral Exam						
Child Dental	Preventive - Cleaning						
Diagnostic	Preventive - X-ray	No charge		No charge			
and Preventive	Sealants per Tooth	140 Glarge		140 Glarge			
	Topical Fluoride Application						
	Space Maintainers - Fixed						
Child Dental	Restorative Procedures			See <u>20202021</u>			
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule			
	Crowns and Casts						
	Endodontics						
Child Dental Major	Periodontics (other than maintenance)	50%		See 2020 2021 Dental Copay			
Services		JU /0		Schedule			
	Prosthodontics						
Child	Oral Surgery						
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000			

20202021 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 16, 2019 January 9, 2020

_	, 2019 January 9, 2020 nefits and Coverage				
-	amounts describe the Enrollee's out of pocket costs.	Individual-only		Individual-only	
	<u>'</u>	Coinsurance	Plan	Copay Pla	
Actuarial Value - A		81.8%		78.3% <u>78.1</u>	<u>%</u>
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum			\$7,800 <u>\$7,9</u>	
	Family Out-of-pocket maximum	\$15,600 <u>\$15,</u>	900	\$15,600 <u>\$15,</u>	900
	HSA plan: Self-only coverage deductible	N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Haalth aans	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's office or clinic visit	Other practitioner office visit	\$30		\$30	
visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20% <u>\$275</u>		\$275	
	Tier 1	\$15 <u>\$16</u>		\$15 <u>\$16</u>	
Drugs to treat	Tier 2	\$55		\$55	
illness or condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$30		\$30	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$30		\$600 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%		5 days No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$30		\$30	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30		\$30	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
gs.,	Home health care (cost share per visit)	20%		\$30	
		\$30		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services			\$300 \$300 per day up to	
other special health needs	Skilled nursing care	20%		5 days	
nearth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	. No onarge		140 Glaige	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	20%		See 20202021	
Basic Services	Periodontal Maintenance Services	2070		Dental Copay Schedule	
	Crowns and Casts				
Object of	Endodontics			Co- 00000001	
Child Dental Major	Periodontics (other than maintenance)	50%		See 20202021 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	
Orthodontics					

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provider or calling of the presidence of the visit of the vi		Primary care visit to treat an injury, illness, or condition	\$25 <u>\$20</u>		\$25 <u>\$35</u>	
Preventive carrier screening immunization	provider's	Other practitioner office visit	\$2 5 <u>\$20</u>		\$2 5 <u>\$35</u>	
Preventive care' screening immunication Laboratory relat Laboratory relative Laboratory Labo		Specialist visit	\$50		¢50¢55	
Leboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scarns, MRIs) Ter 1 Ter 2 Selection Time 2 Surgery Builty fine (e.g., ASC) Physicianistrageon fees Outpatients services Outpatient services Fine 2 Services Outpatient	VISIL					
Tests		·	-		_	
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Time 2 Time 2 Time 3 Time 4 Time 5 Time 4 Time 5 Time 4 Time 6 Time 6 Time 6 Time 7 Time 7 Time 7 Time 7 Time 7 Time 7 Time 8 Surgery facility fee (e.g., ASC) Physician-burgeon fees Outpatient services Outpatient visit Time 8 Time 8 Time 9 Time 9 Time 1 Time 9 Surgery facility fee (e.g., ASC) Physician-burgeon fees Outpatient visit Time 9 Time 9 Time 1 Time 9 Surgery facility fee (e.g., ASC) Physician-burgeon fees Outpatient visit Time 1 Time 9 Time 9 Time 1 Time 9 Surgery facility fee (e.g., ASC) Physician-burgeon fees Outpatient visit Time 9 Time 9 Time 1 Time 9 Time 9 Time 1 Time 9 Surgery facility fee (e.g., ASC) Time 9 Time 1 Time 9 Time 1 Time 9 Time 4 Time 4 Time 9 Surgery facility fee (e.g., ASC) Time 9 Time 1 Time 1 Time 1 Time 1 Time 1 Time 4 Time 4 Time 4 Time 1 Time 1 Time 1 Time 1 Time 4 Time 4 Time 4 Time 4 Time 4 Time 4 Time 6 Time 4 Time 4 Time 4 Time 4 Time 6 Time 4 Time 4 Time 6 Ti		Imaging (CT/PET scans, MRIs)	20%	X	\$275 <u>\$250</u>	X
Tier 3 Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient services Outpatient visit Need immediate emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Need immediate emergency room facility fee (waived if admitted) Need immediate emergency room facility fee (waived if admitted) No charge Hospital stay facility fee (e.g., Inospital room) for inpatient stay (including labor and elitery, metal hands, or substance use disorder outpatient office white health, or substance use disorder outpatient office white substance use disorder outpatient office white substance use disorder outpatient office white substance was substance whose needs white substance use disorder outpatient office white substance was substance whose needs white substance was disorder outpatient office white substance was substance whose needs white substance was disorder outpatient office white substance was substance was disorder outpatient office white substance was disorder outpatient outpatient white substance was disorder outpatient outpatient white substance was disorder outpatient out		Tier 1	\$15		\$15	
tilness or condition Tier 3 Tier 4 Tier 5 Tier 4 Tier 4 Tier 4 Tier 4 Tier 5 Tier 4 Tier 5 Ti	Drugs to treat	Tier 2	\$ 5 0 <u>\$40</u>		\$ 5 0 <u>\$40</u>	
Surgery facility fee (e.g., ASC) Cutpatient services Physician/surgeon fees Cutpatient visit Emergency room facility fee (waived if admitted) Modical transportation (including emergency) and non-emergency) Urgent care Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, metal health, and substance use) Physician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, metal health, and substance use) Physician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, metal health, and substance use) Physician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, metal health, and substance use) Physician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, metal health, and substance use) Flysician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, metal health, and substance use) Flysician/surgeon fee Facility fee (e.g., hospital health and substance use) Flysician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, metal health, and substance use) Flysician/surgeon fee Facility fee (e.g., hospital health, and substance use) Floricovering or observation health and substance use) Flysician/surgeon fee Floricovering or observation feet flysician feet flysician feet flysici	illness or	Tier 3	\$ 80 \$70		\$80 <u>\$70</u>	
Surgery facility fee (e.g., ASC) Cutpatient services Physician/surgeon fees Outpatient violt Emergency room facility fee (waived if admitted) Mindical transportation (including emergency) and non-emergency) Urgent care Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Physician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Physician/surgeon fee Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Physician/surgeon fee Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services No charge Pregnancy Pregnancy Premantal care and preconception visits No charge No charge No charge No charge No charge Child eye care Child eye care Child eye care Child eye care Child pertal place of contact lenses in lieu of glasses) No charge Preventive - Cleaning Preventive -		Tier 4	_		_	
Physician/surgeon fees Outpatient visit Red Inmediate attention Need immediate attention Need				V		V
Outpatient visit Rental health, or substance abuse needs Pregnancy Prentalic are and preconception visits No charge Home health ard substance use disorder outpatient office abuse needs Pregnancy Prentalic are and preconception visits No charge Home health rended abuse needs Child Dental Diagnostic and Preventive - Clanning Preventive - Services Periodontities Outpatient Restoration Space Maintainerance Services Periodontities Outpatient Restoration Space Maintainerance Services Periodontities Outpatient Restoration Space Maintainerance Services Periodontities Outpatient Restoration Preventive - Cleaning Preventi	Outpatient			X		X
Emergency room facility fee (waived if admitted) Need immediate attention Emergency room physician fee (waived if admitted) Medical transportation (including emergency and non-emergency) Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgen fee Mental health, or substance abuse needs Mental behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient items and services Mental/behavioral health and substance use disorder outpatient items and services Mental/behavioral health and substance use disorder outpatient items and services Mental/behavioral health and substance use disorder outpatient items and services Mental/behavioral health and substance use disorder outpatient items and services Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visit		Physician/surgeon fees				
Need immediate attention		Outpatient visit	20%		20%	
immediate attention Medical transportation (including emergency and non-emergency) Urgent care Beauty Fee (e.g., hospital stay) Hospital stay Hospital stay Hospital stay Mental health, befavioral health and substance use) Physician/surgeon fee Mental health, behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits Mental behavioral health and substance use disorder outpatient office visits No charge Pregnancy Pregnancy Pregnancy Pregnancy Presental care and preconception visits No charge Skilled nursing care Skilled nursing care Skilled nursing care Skilled nursing care Visits No charge Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Periodontal Maintenance Services Periodontal Maintenance Services Periodontal Maintenance Services No charge No charge		Emergency room facility fee (waived if admitted)	\$250 20%	X	\$250	X
Medical transportation (including emergency and non-emergency) Urgent care Hospital stay Hospital stay Physician/surgeon fee Mental health, or substance use disorder outpatient office abuse needs Pregnancy Pregnancy Prenatal care and preconception visits No charge Help Outpatient Rehabilitation and Habilitation services Scaes 20 Water and Sarvices No charge Home health care (cost share per visit) Substance Urgent care Wental/behavioral health and substance use disorder outpatient office visits No charge Pregnancy Prenatal care and preconception visits No charge No charge Help Outpatient Rehabilitation and Habilitation services Scaes 20 Water and Sarvices Scaes 20 Water and Sarvices Scaes 20 Water and Sarvices No charge No charge No charge No charge Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Preventive - Cleaning Preventive - Cream -		Emergency room physician fee (waived if admitted)	No charge		No charge	
Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services Pregnancy Prenatal care and preconception visits No charge No charge No charge Skilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Ourable medical equipment Durable medical equipment Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Preventive Child Dental Basic Preventive Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics		Medical transportation (including emergency and non-emergency)	\$250	X	\$250	Χ
Hospital stay Physician/surgeon fee Mental health, behavioral health and substance use disorder outpatient office behavioral health or substance abuse needs Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Selide nursing care Durable medical equipment Hospice service Child eye care Child bental Diagnostic and Preventive Preventive Child Dontal Basic Services Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Amental/behavioral health and substance use disorder outpatient office sets 52520 S25535 S26520 S26535 S300 S30 S30 S30 S30 S30 S30 S30 S30 S20 S25535 Scelled nursing care According to the health care (cost share per visit) Scelled nursing care Durable medical equipment Durable medical equipment Durable medical equipment Scelled nursing care No charge Preventive - Cleaning Preventive - Cleaning Preventive - Scellation Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Endodontics		Urgent care	\$ 25 \$20		\$ 25 \$35	
Hospital stay Physician/surgeon fee Physician Surgeon Physician Physic			20%	X	\$600 per day up to 5 days	X
Mental health, behavioral health and substance use disorder outpatient office visits whether outpatient phental care and preconception visits. Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient substance use disorder other outpatient substance use disorder other outpatient items and services No charge Restorative Procedures Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics	Hospital stay					^
No charge		Physician/surgeon ree	20%	X	No charge	
health, or substance abuse needs items and services whetai/Dehavioral health and substance use disorder other outpatient items and services items and services whetai/Dehavioral health and substance use disorder other outpatient items and services whetai/Dehavioral health and substance use disorder other outpatient subseanceds items and services whetai/Dehavioral health an			\$25 <u>\$20</u>		\$25 <u>\$35</u>	
abuse needs litems and services litems and ser	health, or	· · · · · · · · · · · · · · · · · · ·				
Home health care (cost share per visit) Precovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Home health care (cost share per visit) San San San San San San San Sa			\$ 2 5 <u>\$20</u>		\$25 <u>\$35</u>	
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive - Cleaning Preventive Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Outpatient Rehabilitation and Habilitation services \$25\$20 \$20% X \$300 per day up to 5 days AV \$400 charge No charge No charge No charge No charge AV No charge AV No charge AV No charge AV Sealants per Tooth Av Topical Fluoride Application Space Maintainers - Fixed AV Child Dental Basic Services Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av Topical Fluoride Application Av Sealants per Tooth Av	Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Skilled nursing care Other special health needs Durable medical equipment Hospice service No charge Skilled nursing care Durable medical equipment Durable medical equipment Hospice service No charge No charge No charge Sey exam Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Endodontics Skilled nursing care 20% X \$300 per day up to 5 days A \$20% No charge No charge No charge No charge No charge No charge No charge No charge See 20202021 Dental Copay Schedule		Home health care (cost share per visit)	\$30		\$30	
Skilled nursing care other special health needs Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Copay Schedule	Heln	Outpatient Rehabilitation and Habilitation services	\$25 \$20		\$25 \$35	
thealth needs health needs Durable medical equipment 20% 20% 20% Hospice service No charge No charge No charge Child eye care Eye exam No charge No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Restorative Procedures Periodontal Maintenance Services Endodontics Endodontics Endodontics Durable medical equipment 20% No charge No charg	recovering or	·		Y		X
Hospice service Hospice service No charge Child Dental Diagnostic and Preventive Child Dental Diagnostic and Preventive Child Dental Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics	•			^		^
Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Eye exam No charge No charge No charge No charge						
Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Diagnostic and Preventive - Child Dental Services Child Dental Dental Copay Schedule Child Dental Basic Services Crowns and Casts Endodontics		·			-	
1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Preventive Procedures Periodontal Maintenance Services No charge	Child eye care		_			
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Preventive - X-ray No charge		1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge		Oral Exam				
Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge	01:11:2	Preventive - Cleaning				
and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics		Preventive - X-ray	No al		No ob	
Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics See 2020 2021 Dental Copay Schedule	and	Sealants per Tooth	ino charge		ino charge	
Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Space Maintainers - Fixed Restorative Procedures 20% See 20202021 Dental Copay Schedule	rreventivé	Topical Fluoride Application				
Child Dental Basic Services Restorative Procedures Periodontal Maintenance Services 20% See 20202021 Dental Copay Schedule Crowns and Casts Endodontics						
Basic Services Periodontal Maintenance Services 20% See 2020201 Dental Copay Schedule Schedule Schedule	Child Dental				Sec 20202024 5 4 4 2	
Crowns and Casts Endodontics	Basic		20%			
Endodontics	031 VICE3					
Child Dental See 20202021 Dental Copay					See 2020 2021 Dental Copav	
Services Schedule			50%			
Prosthodontics						
Oral Surgery Child Madically access and advantage of the control	Child	• •				
Child Medically necessary orthodontics 50% \$1,000		Medically necessary orthodontics	50%		\$1,000	

20202021 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 16, 2019 January 9, 2020

Summary of Benefits and Coverage					
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Individual-only Silver Plan				
Actuarial Value - AV Calculator	71.8% <u>71.0%</u>				
Plan design includes a deductible?	Yes, Medical/Pharmacy				
Integrated Individual deductible	N/A				
Integrated Family deductible	N/A				
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$0				
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$0				
Individual Out-of-pocket maximum	\$7,800 <u>\$7,950</u>				
Family Out-of-pocket maximum	\$15,600 <u>\$15.900</u>				
HSA plan: Self-only coverage deductible	N/A				
HSA family plan: Individual deductible	N/A				

	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit	\$40	
office or clinic	·		
VISIT	Specialist visit	\$80	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmacy deductible
_	Tier 2	\$60	Pharmac
Drugs to treat illness or	1161 2	φου	deductible Pharmac
condition	Tier 3	\$90	deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductible
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$40	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20% 20%	Х
		2070	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$40	
recovering or other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
01:11	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
01:11.7	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	140 onlingo	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
Child	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

_	, 2019 January 9, 2020	0000		0000	
•	nefits and Coverage	CCSB-only Silver		CCSB-only Silver	
	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan	1	Copay Plan	
Actuarial Value - A		70.5% <u>70.2%</u>		70.2% <u>69.4%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$6	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$4,500 / \$600 / \$0 \$7,800 \$7,950		\$4,500 / \$600 / \$600 \$600	J
	Family Out-of-pocket maximum			\$15,600\$15,900	
	HSA plan: Self-only coverage deductible	· · · · —		N/A	
	HSA family plan: Individual deductible			N/A	
Common			Deductible		Deductible
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies
Haralda a san	Primary care visit to treat an injury, illness, or condition	\$50		\$50 <u>\$60</u>	
Health care provider's	Other practitioner office visit	\$50		\$ 5 0 <u>\$60</u>	
office or clinic visit	Specialist visit	\$85		\$ 85 <u>\$90</u>	
	Preventive care/ screening/ immunization				
	· ·	No charge		No charge	
Tests	Laboratory Tests	\$40 <u>\$50</u>		\$40 <u>\$60</u>	
resis	X-rays and Diagnostic Imaging	\$85	V	\$85 <u>\$90</u>	V
	Imaging (CT/PET scans, MRIs)	20% 35%	X	\$300	X
	Tier 1	\$17 <u>\$20</u>	Pharmacy deductible	\$17 <u>\$20</u>	Pharmacy deductible
Down to treat	Tier 2	\$ 65 \$70	Pharmacy	\$65 \$80	Pharmacy
Drugs to treat illness or		\$33 <u>\$4.5</u>	deductible Pharmacy	\$00 <u>\$00</u>	deductible Pharmacy
condition	Tier 3	\$ 90 \$100	deductible	\$ 90 \$110	deductible
	Tier 4	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility for (a.g. ASC)			. ,	
Outpatient	Surgery facility fee (e.g., ASC)	20% 35%	X	20% 35%	X
services	Physician/surgeon fees	20% 35%		20% <u>35%</u>	
	Outpatient visit	20% <u>35%</u>		20% 35%	
	Emergency room facility fee (waived if admitted)	\$400	Х	\$400 <u>\$35%</u>	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	X
	Urgent care	\$50		\$50 <u>\$60</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20% 35%	X	20% 35%	Х
Hospital stay	Physician/surgeon fee	20% 35%	X	20% 35%	
	•	2070 <u>3010</u>	,	2070	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$50 <u>\$60</u>	
health, or substance	Montal/behavioral health and substance use disorder other autrations				
abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$ 50 <u>\$60</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20% 35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$ 5 0 <u>\$60</u>	
recovering or	Skilled nursing care	20% 35%	X	20% 35%	x
other special health needs			^		^
	Durable medical equipment	20% 35%		20% 35%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	110 0112190		. To shange	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2020 2021 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		Schedule Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 20202021 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child		F00/		04.000	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Summary of Be	nefits and Coverage	CCSB-or	nly
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver HDHP Pl	an
ctuarial Value - A	N Calculator	71.3% 71.8	
	Plan design includes a deductible?	Yes, integra	ated
	Integrated Individual deductible	\$2,500 integ	rated
	Integrated Family deductible	\$5,000 integ	rated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$6,850	
	Family Out-of-pocket maximum	\$13,700	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$2,500 See endne	
_	The state of the s	oco onan	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	20%	Х
Health care provider's office or clinic	Other practitioner office visit	20%	Х
visit	Specialist visit	20%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	Χ
Tests	X-rays and Diagnostic Imaging	20%	Х
	Imaging (CT/PET scans, MRIs)	20%	X
	Tier 1	20% up to \$250 per script	Х
Drugs to treat	Tier 2	20% up to \$250 per script	X
illness or condition	Tier 3	20% up to \$250 per script	Х
	Tier 4	20% up to \$250 per script	Х
	Surgery facility fee (e.g., ASC)	20%	X
Outpatient services	Physician/surgeon fees	20%	Х
SEI VICES	Outpatient visit	20%	Х
	Emergency room facility fee (waived if admitted)	20%	X
Need	Emergency room physician fee (waived if admitted)	0%	X
mmediate attention	Medical transportation (including emergency and non-emergency)	20%	Х
attention	Urgent care	20%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	20%	Х
	Physician/surgeon fee	20%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	Х
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	х
Pregnancy	Prenatal care and preconception visits	No charge	
Tognancy	Home health care (cost share per visit)	20%	Х
Help recovering or	Outpatient Rehabilitation and Habilitation services	20%	X
other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	Χ
	Hospice service	0%	Х
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental Diagnostic	Preventive - Cleaning		
	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	3-	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	20 /0	
	Crowns and Casts		

Periodontics (other than maintenance)

Medically necessary orthodontics

Crowns and Casts Endodontics

Prosthodontics Oral Surgery

Child Dental Major Services

50%

50%

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan	
Actuarial Value - A	V Calculator	100%-150% 94.5%94		150%-200% FPL 87.7%8 7.9%	
totaariai valdo - 7-	Plan design includes a deductible?			Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	namaoy	N/A	acy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$1,400 / \$100 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/\$0	\$2,800 / \$200 / \$	0
	Individual Out-of-pocket maximum	\$1,000	0	\$2,700 <u>\$2,750</u>	
	Family Out-of-pocket maximum	\$2,000	0	\$5,400 <u>\$5,500</u>	
HSA plan: Self-only coverage deductible		N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's office or clinic	Other practitioner office visit	¢E.		\$15	
	Other practitioner office visit	\$5		\$15	
visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5 <u>\$10</u>	
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
illness or condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4	10% up to \$150 per		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$150 <u>\$175</u>	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	Х	15%	X
	Physician/surgeon fee	10%		15%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Holp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or			X		Х
other special health needs	Skilled nursing care	10%	^	15%	Α
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
, o our o	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental		E00/		E00/	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

20202021 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 16, 2019 January 9, 2020

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan		
Actuarial Value - A	·	200%-250% FPI	-	
Actuariai value - A	Plan design includes a deductible?	73.9% 73.6% Yes, Medical/Pharm	acv.	
	Integrated Individual deductible	N/A	iacy	
	Integrated Family deductible	N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 / \$275 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$550 / \$0		
	Individual Out-of-pocket maximum	\$6,500		
	Family Out-of-pocket maximum	\$13,000		
	HSA plan: Self-only coverage deductible	N/A		
	HSA family plan: Individual deductible	N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic	Primary care visit to treat an injury, illness, or condition	\$35		
	Other practitioner office visit	\$35		
visit	Specialist visit	\$75		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$40		
Tests	X-rays and Diagnostic Imaging	\$85		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$16	Pharmacy	
			deductible Pharmacy	
Drugs to treat illness or	Tier 2	\$55	deductible	
condition	Tier 3	\$85	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
	Surgery facility fee (e.g., ASC)	20%		
Outpatient services	Physician/surgeon fees	20%		
	Outpatient visit	20%		
	Emergency room facility fee (waived if admitted)	\$400		
Need	Emergency room physician fee (waived if admitted)	No charge		
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		
	Urgent care	\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	Х	
Mental health,	Mental/behavioral health and substance use disorder outpatient office			
behavioral health, or	visits	\$35		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$40		
Help	Outpatient Rehabilitation and Habilitation services	\$35		
recovering or	Skilled nursing care	20%	X	
other special health needs			Α	
	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray	No charge		
and Preventive	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	20%		
Services	Periodontal Maintenance Services			
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	50%		
20.11003	Prosthodontics			
	Oral Surgery			
Child				

Summary of Benefits and Coverage						
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n	
Actuarial Value - A	AV Calculator	61.4% <u>64.71%</u>		62.1% <u>64.6</u> 9	<u>%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integrat		
	Integrated Individual deductible	N/A		\$6,900 <u>\$7,000</u> into	-	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$6,300 / \$500 \$750	/\$0	\$13,800 <u>\$14,000</u> integrated N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$ 1,000 \$1,5		N/A		
	Individual Out-of-pocket maximum	\$ 7,800 \$ <u>7,950</u>		See endnot	e	
	Family Out-of-pocket maximum	\$15,600 <u>\$15.90</u> 0	<u>)</u>	See endnot	e	
	HSA plan: Self-only coverage deductible	N/A		\$6,900 <u>\$7,0</u> 0	<u>00</u>	
	HSA family plan: Individual deductible	tible N/A		\$ 6,900 \$7,00	<u>00</u>	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$65 <u>\$95</u>	After 1st three non- preventive visits	0%	Х	
Health care provider's office or clinic	Other practitioner office visit	\$ 65 <u>\$95</u>	After 1st three non- preventive visits	0%	x	
visit	Specialist visit	\$95 <u>\$125</u>	After 1st three non- preventive visits	0%	X	
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge		
	Laboratory Tests	\$40	<u>×</u>	0%	Х	
Tests	X-rays and Diagnostic Imaging	40%	×	0%	Х	
	Imaging (CT/PET scans, MRIs)	40%	X	0%	х	
	Tier 1	\$18	Pharmacy	0%	x	
Drugs to treat illness or condition		40% up to \$500 per script after	Deductible Pharmacy			
	Tier 2	pharmacy deductible	Deductible	0%	Х	
	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X	
	Tier 4	40% up to \$500 per script after	Pharmacy	0%	X	
	Surgery facility fee (e.g., ASC)	pharmacy deductible 40%	Deductible X	0%	Х	
Outpatient services	Physician/surgeon fees	40%	X	0%	X	
	Outpatient visit	40%	X	0%	X	
	Emergency room facility fee (waived if admitted)	40%	X	0%	X	
Need	Emergency room physician fee (waived if admitted)	No charge	^	0%	X	
immediate	Medical transportation (including emergency and non-emergency)	40%	X	0%	X	
attention	Urgent care	\$ 65 \$95	After 1st three non-	0%	X	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		preventive visits			
Hospital stay	delivery, mental health, and substance use)	40%	X	0%	Х	
	Physician/surgeon fee	40%	X	0%	X	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65 <u>\$95</u>	After 1st three non- preventive visits	0%	Х	
health, or substance	Mental/behavioral health and substance use disorder other outpatient					
abuse needs	items and services	\$ 65 \$ <u>95</u>	X	0%	Х	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	40%	X	0%	X	
Help	Outpatient Rehabilitation and Habilitation services	\$65 <u>\$95</u>		0%	Х	
recovering or other special	Skilled nursing care	40%	X	0%	X	
health needs	Durable medical equipment	40%	X	0%	X	
	Hospice service	No charge		0%	X	
Child eye care	Eye exam	No charge		No charge		
- I Jo Guid	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	No charge		No charge		
and Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		20%		
Services	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	50%		50%		
	Prosthodontics					
Child	Oral Surgery					
Orthodontics	Medically necessary orthodontics	50%		50%		

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Date: May 16, 2019 January 9, 2020					
Summary of Be	enefits and Coverage				
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Catast	trophic Plan		
Actuarial Value - A	AV Calculator				
	Plan design includes a deductible?	Yes,	integrated		
	Integrated Individual deductible	\$8,150 <u>\$8</u>	,300 integrated		
Integrated Family deductible		\$16,300 <u>\$16,600</u> integrated			
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A			
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A			
	Individual Out-of-pocket maximum	\$8, <u>150</u> \$8,300			
	Family Out-of-pocket maximum	\$16,300 <u>\$16,600</u>			
	HSA plan: Self-only coverage deductible	N/A			
HSA family plan: Individual deductible			N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies		
	Primary care visit to treet an injury illness, or condition	00/-	After 1st three non-		

	Family Out-of-pocket maximum	m \$16,300 <u>\$16,600</u>	
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three nor preventive visits
Health care provider's office or clinic	Other practitioner office visit	0%	After 1st three no preventive visits
visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	Х
	Tier 1	0%	Х
Drugs to treat	Tier 2	0%	Х
illness or condition	Tier 3	0%	X
	Tier 4	0%	x
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient services	Physician/surgeon fees	0%	Х
30.1.000	Outpatient visit	0%	Х
	Emergency room facility fee (waived if admitted)	0%	Х
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	0%	Х
	Urgent care	0%	After 1st three no
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X
i ioopitai otay	Physician/surgeon fee	0%	Х
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visits
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	×
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	Х
	Hospice service	0%	Х
	Eye exam	No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	0%	Х
	Crowns and Casts		
	Endodontics		
Child Dental	Periodontics (other than maintenance)	0%	Х
Major	*		
Major Services	Prosthodontics		
	Prosthodontics Oral Surgery		

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Summary of Benefits and Coverage



ividual-only Platinum Coinsurance Plan Individual-only Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs. Copay Plan Actuarial Value - AV Calculator 89.189.3% 91.791.6% Plan design includes a deductible? No No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Individual Out-of-pocket maximum \$4,500 \$4,500 Family Out-of-pocket maximum \$9,000 \$9,000 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Member Cost Member Cost Common Deductible Deductible Service Type Medical Event Share Applies Share Applies Primary care visit to treat an injury, illness, or condition \$15 \$15 Health care provider's office or clinic Other practitioner office visit \$15 \$15 visit Specialist visit \$30 \$30 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$15 \$15 Tests X-rays and Diagnostic Imaging \$30 \$30 Imaging (CT/PET scans, MRIs) 10% \$75 Tier 1 \$5 \$5 Drugs to treat Tier 2 \$15 \$15 condition Tier 3 \$25 10% up to \$250 per 10% up to \$250 per Tier 4 script Surgery facility fee (e.g., ASC) \$100 10% Outpatient Physician/surgeon fees 10% \$25 services Outpatient visit 10% 10% Emergency room facility fee (waived if admitted) \$150 \$150 Emergency room physician fee (waived if admitted) No charge No charge immediate Medical transportation (including emergency and non-emergency) \$150 \$150 attention Urgent care \$15 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) \$250 per day up to 10% Hospital stay Physician/surgeon fee 10% No charge Mental/behavioral health and substance use disorder outpatient office Mental health. \$15 \$15 behavioral health, or Mental/behavioral health and substance use disorder other outpatient \$15 \$15 abuse needs items and services Pregnancy Prenatal care and preconception visits No charge No charge Home health care (cost share per visit) \$20 10% Outpatient Rehabilitation and Habilitation services \$15 \$15 Help recovering or \$150 per day up to Skilled nursing care 10% other special health needs 5 days Durable medical equipment 10% 10% Hospice service No charge No charge Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic and Preventive Not Covered Not Covered Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Child Dental Not Covered Not Covered Periodontal Maintenance Services Crowns and Casts Endodontics **Child Dental** Periodontics (other than maintenance) Not Covered Not Covered **Major Services** Prosthodontics Medically necessary orthodontics Not Covered Not Covered

20202021 Patient-Centered Benefit Plan Designs 9.5 EHB Date: May 16, 2019 January 9, 2020

_	, 2019<u>January 9, 2020</u> nefits and Coverage	CCSB-on		CCSB-on	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance		Platinum Copay Pla	
Actuarial Value - A	V Calculator	91.7% 90.6	<u>%</u>	89.1% 88.1	<u>%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$250</u> / \$0	/ \$0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$500</u> / \$0	/ \$0	\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$4,500		\$4,500 <u>\$4,0</u>	
	Family Out-of-pocket maximum	\$9,000 N/A		\$9,000 <u>\$8,0</u>	<u>00</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
_	To that my plant matrical code and				
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Hoolth core	Primary care visit to treat an injury, illness, or condition	\$15		\$15 <u>\$20</u>	
Health care provider's office or clinic visit	Other practitioner office visit	\$15		\$15 <u>\$20</u>	
	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15 <u>\$20</u>	
Tests	X-rays and Diagnostic Imaging	\$30		\$30 \$40	
	Imaging (CT/PET scans, MRIs)	10%	<u>X</u>	\$75 \$150	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15 <u>\$30</u>		\$15	
illness or condition	Tier 3	\$25 \$50		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	Surgery facility fee (e.g., ASC)	script	<u>x</u>	script \$100	
Outpatient services	Physician/surgeon fees	10%	<u> </u>	\$25	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$ 150 <u>10%</u>	X	\$150 <u>\$250</u>	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15 <u>\$20</u>	
Harakini atau	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	<u>X</u>	\$250 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%	<u>X</u>	No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$15		¢15¢20	
behavioral health, or	visits	\$15		\$15 <u>\$20</u>	
substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15 <u>\$20</u>	
abuse needs	items and services				
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15 <u>\$20</u>	
recovering or other special	Skilled nursing care	10%	<u>X</u>	\$150 per day up to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive	Sealants per Tooth	No charge		Not Covered	
and Freventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	20%		Not Covered	
20.000	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		Not Covered	

	•	*				
Summary	of B	nofite	and	Cava	ran	_

Summary of Be	nefits and Coverage	Individual cals	Cold	Individual only	. Cold
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
Actuarial Value - A	V Calculator	81.8%		78.3% <u>78.1</u>	<u>%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum			\$7,800 <u>\$7,9</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$15,600 <u>\$15,</u> 9 N/A	<u>900</u>	\$15,600 <u>\$15,</u> N/A	<u>900</u>
	HSA family plan: Individual deductible			N/A	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
provider's office or clinic	Other practitioner office visit	\$30		\$30	
visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20% \$275		\$275	
	Tier 1	\$15 <u>\$16</u>		\$15 <u>\$16</u>	
Drugs to treat	Tier 2	\$55		\$55	
illness or condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per		20% up to \$250 per	
	Her 4	script		script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$30		\$30	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%		\$600 per day up to	
Hospital stay	delivery, mental health, and substance use)			5 days	
	Physician/surgeon fee	20%		No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$30		\$30	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30		\$30	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
recovering or	Skilled nursing care	20%		\$300 per day up to	
other special health needs	Durable medical equipment	20%		5 days 20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not Covered		Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services	Prosthodontics				
	Oral Surgery				
Child		Not O		Not O	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Summary of Be	nefits and Coverage	CCSB-only Gold		CCSB-only Gold	
	amounts describe the Enrollee's out of pocket costs.	Coinsurance Pla	n	Copay Plan	
Actuarial Value - A		78.1% <u>78.3%</u>		79.7% <u>79.4%</u>	
	Plan design includes a deductible?		acy	Yes, Medical/Pharr	nacy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$250\$500 / \$0 / \$	0	\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$500\$1,000 / \$0 / \$		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$25 <u>\$20</u>		\$25 <u>\$35</u>	
Health care provider's	Other practitioner office visit	\$ 25 \$20		\$ 25 \$35	
office or clinic	Connectical scients	450		950955	
visit	Specialist visit	\$50		\$50 <u>\$55</u>	
	Preventive care/ screening/ immunization	No charge \$25		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$25 \$65 <u>\$50</u>		\$25 <u>\$35</u> \$65 <u>\$55</u>	
	Imaging (CT/PET scans, MRIs)	20%	<u>×</u>	\$ 275 \$250	×
			<u> </u>		2
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50 <u>\$40</u>		\$50 <u>\$40</u>	
condition	Tier 3	\$ 80 \$70		\$80 <u>\$70</u>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%	<u>X</u>	\$300	<u>X</u>
Outpatient services	Physician/surgeon fees	20%		\$40 <u>\$35</u>	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$250 20%	X	\$250	Χ
Need immediate attention	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	X
	Urgent care	\$25 <u>\$20</u>		\$25 \$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х	\$600 per day up to 5 days	X
Hospital stay	Physician/surgeon fee	20%	X	No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office				
behavioral	visits	\$25 <u>\$20</u>		\$25 \$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	******		******	
abuse needs	items and services	\$ 25 \$20		\$25 <u>\$35</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$30		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25 <u>\$20</u>		\$25 \$35	
recovering or other special	Skilled nursing care	20%	×	\$300 per day up to 5 days	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Ohild	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray	N . 2		N . 2	
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services	Prosthodontics				
	Oral Surgery				
Child		Not Covered		Not Covered	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Summary of Benefits and Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
Actuarial Value - A	·	71.8%71.0%	riaii
Actuariai value - A	V Calculator Plan design includes a deductible?	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	acy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$6	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$	0
	Individual Out-of-pocket maximum	\$7,800 <u>\$7,950</u>	
	Family Out-of-pocket maximum	\$15,600 <u>\$15,900</u>	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$40	
provider's office or clinic	Other practitioner office visit	\$40	
visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmacy deductible
Drugs to treat	Tier 2	\$60	Pharmacy deductible
illness or condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy deductible
	Surgery facility foo (o.g. ASC)	after pharmacy deductible 20%	deductible
Outpatient	Surgery facility fee (e.g., ASC)		
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$40	
Here Make to the co	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
Hospital stay	Physician/surgeon fee	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
	Outpatient Rehabilitation and Habilitation services		
Help recovering or		\$40	
other special health needs	Skilled nursing care	20%	Х
.iouitii iiocus	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
jo 3010	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental	Periodontics (other than maintenance)	Not Covered	
Major Services	Prosthodontics		
	Oral Surgery		
Child	· .	Not Covered	
Orthodontics	Medically necessary orthodontics	Not Covered	

	nefits and Coverage	CCSB-only		CCSB-only	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plar	1	Silver Copay Plan	
Actuarial Value - A	V Calculator	70.5% <u>70.2%</u>		70.2% 69.4%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	•
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$ \$4,500 / \$600 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$4,500 / \$600 / \$0 \$7,800 \$7,950		\$4,500 / \$600 / \$ \$ 7,800 \$7,950	J
	Family Out-of-pocket maximum			\$15,600 <u>\$15,900</u>	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50		\$ 50 \$60	
Health care provider's	Other practitioner office visit	\$50		\$50 <u>\$60</u>	
office or clinic	,			_	
visit	Specialist visit	\$85		\$ 85 \$ <u>90</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
Toeto	Laboratory Tests Y-rays and Diagnostic Imaging	\$40 <u>\$50</u> \$85		\$40 <u>\$60</u> \$85\$90	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		V	\$85 <u>\$90</u> \$300	V
		20% 35%	X Pharmacy	·	X Pharmacy
	Tier 1	\$17 <u>\$20</u>	deductible	\$17 <u>\$20</u>	deductible
Drugs to treat	Tier 2	\$65 <u>\$70</u>	Pharmacy deductible	\$65 <u>\$80</u>	Pharmacy deductible
illness or condition	Tier 3	\$ 90 \$100	Pharmacy	\$90 \$110	Pharmacy
Condition	Tiel 3		deductible		deductible
	Tier 4	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20% 35%	<u>X</u>	20 % <u>35%</u>	<u>X</u>
Outpatient services	Physician/surgeon fees	20% 35%		20% 35%	
361 11663	Outpatient visit	20% 35%		20% 35%	
	Emergency room facility fee (waived if admitted)	\$400	Х	\$4 00 \$35%	X
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	Х
	Urgent care	\$50		\$50 <u>\$60</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20% 35%	X	20% 35%	X
Hospital stay	delivery, mental health, and substance use)				Α
	Physician/surgeon fee	20% 35%	Х	20% 35%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$50 \$60	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$50		\$50 <u>\$60</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20% <u>35%</u>		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$50 <u>\$60</u>	
recovering or other special	Skilled nursing care	20% 35%	X	20% 35%	X
health needs	Durable medical equipment	20% 35%		20% 35%	
	Hospice service	No charge		No charge	
0.1.	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive		Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services	Prosthodontics				
	Oral Surgery				
Child		N. (2)		N. (2)	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

	-2019January 9, 2020	CCSP or	alv	
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-or		
Actuarial Value - A	·	HDHP Plan 71.3%71.8%		
Actuarial value - A	Plan design includes a deductible?	Yes, integr		
	Integrated Individual deductible	\$2,500 integ		
	Integrated Family deductible	\$5,000 integrated		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A		
	Individual Out-of-pocket maximum		1	
	Family Out-of-pocket maximum	\$13,700	0	
	HSA plan: Self-only coverage deductible	\$2,500 See endn		
	HSA family plan: Individual deductible	See enun	ote	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care	Primary care visit to treat an injury, illness, or condition	20%	Х	
provider's	Other practitioner office visit	20%	Х	
office or clinic visit	Specialist visit	20%	х	
Viole	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	20%	X	
Tests	X-rays and Diagnostic Imaging	20%	Х	
	Imaging (CT/PET scans, MRIs)	20%	Х	
	Tier 1	20% up to \$250 per	х	
	T. 0	script 20% up to \$250 per		
Drugs to treat illness or condition	Tier 2	script	X	
	Tier 3	20% up to \$250 per script	Х	
	Tier 4	20% up to \$250 per script	Х	
	Surgery facility fee (e.g., ASC)	20%	Х	
Outpatient services	Physician/surgeon fees	20%	Х	
	Outpatient visit	20%	Х	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	Х	
	Emergency room physician fee (waived if admitted)	0%	Х	
	Medical transportation (including emergency and non-emergency)	20%	Х	
	Urgent care	20%	Х	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	
Hospital stay	Physician/surgeon fee	20%	Х	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	000/		
behavioral health, or	visits	20%	X	
substance	Mental/behavioral health and substance use disorder other outpatient	20%	X	
abuse needs	items and services	2070	^	
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	20%	Х	
Help	Outpatient Rehabilitation and Habilitation services	20%	X	
recovering or other special	Skilled nursing care	20%	Х	
health needs	Durable medical equipment	20%	X	
	Hospice service	0%	X	
	Eye exam	No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
	Preventive - Cleaning			
Child Dental	Preventive - X-ray			
Diagnostic and Preventive	Sealants per Tooth	Not Covered		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
	Endodontics			
Child Dental	Periodontics (other than maintenance)	Not Covered		
Major Services	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	Not Covered		
Orthodontics	Modrodity Heoessally Official High	INOL Covered		

Profession Pro		amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan 150%-200% FPL	
Part	Actuarial Value - A	V Calculator	100%-150% FPL 94.5%94.1%			
Part						acy
		-		,		,
Part		Integrated Family deductible	N/A		N/A	
Part		Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$1,400 / \$100 / \$)
Part		Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$2,800 / \$200 / \$	0
Common		Individual Out-of-pocket maximum	\$1,000	0	\$2,700 <u>\$2,750</u>	
Common		Family Out-of-pocket maximum	\$2,000	0	\$5,400 <u>\$5,500</u>	
Mambar Cost Mambar Cost Share Decision		HSA plan: Self-only coverage deductible	N/A		N/A	
Private Priv		HSA family plan: Individual deductible	N/A		N/A	
Name		Service Type			Member Cost Share	
Fine of collect of col	Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
viail to Provertive cases acreeding internatization 36 No. charge (No. charge) Paramacy (Other practitioner office visit	\$5		\$15	
Laboratory Tests		Specialist visit	\$8		\$25	
Tests X-rays and Diagnostic imaging Imaging CPPET carea, MR1a) Ter 1 Ter 1 Ter 2 Time 2 Time 3 Surgery Starting the (e.g., ASC) Pharmacy condition Time 4 Ti		Preventive care/ screening/ immunization	No charge		No charge	
The 1 Text 1 Text 2 Text 3 Text 2 Text 3 Text 3 Text 3 Text 3 Text 4 Tex		Laboratory Tests	\$8		\$20	
Tire 1	Tests	X-rays and Diagnostic Imaging	\$8		\$40	
Drugs to treat illiness or condition Ter 3 Ter 4 Ter 3 Surgery facility fee (e.g. ASC) Outpatient services Surgery facility fee (e.g. ASC) Outpatient services Cutpatient upon fees Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC)		Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat illiness or condition Ter 3 Ter 4 Ter 3 Surgery facility fee (e.g. ASC) Outpatient services Surgery facility fee (e.g. ASC) Outpatient services Cutpatient upon fees Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC) 10% Surgery facility fee (e.g. ASC)		Tier 1				
Drugs to freat limes or condition The 3 Congression of the control of the contro			φυ		क् र <u>क 10</u>	DI
Titer 3 Titer 3 Titer 4 Titer		Tier 2	\$10		\$25	
The 4 10% up to \$150 per script after pharmacy deductible deductible control of the pharmacy deductible and the ph		Tier 3	\$15		\$45	Pharmacy
Surgery facility fee (e.g., ASC) Outpatient enviroes Physican-hourpeen fees Outpatient visit Need Immediate Medical transportation (including emergency) Urgent care Facility fee (e.g. hospital story) Urgent care Footing fee (e.g. hospital story) Formation and substance use disorder outpatient office wish abundance use disorder outpatient office wish abundance abuse mixed activation abuses mixed abuse mixed activation and substance use disorder outpatient office wish abundance abuses mixed abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abuses mixed activation and substance use disorder outpatient office wish abundance abundance activation and substance use disorder outpatient office wish abundance abundance activation and substance use disorder outpatient office wish abundance abundance activation and substance use disorder outpatient office wish abundance abundance activation and substance wish abundance abundance activation and substance						
Outpatient services Physician/surgeon fees 10% 15% Outpatient visit 10% 15% Need immodulate attention Emergency room facility fee (waived if admitted) No charge No charge Hospital stay Modical transportation (including emergency and non-emergency) \$30 \$75 Urgent care \$5 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, merital health, and substance use) 10% X 15% X Mental Inbalth, behavioral health and substance use disorder outpatient office visits \$5 \$15 \$15 Westall/behavioral health and substance use disorder outpatient office visits \$5 \$15 \$15 Westall/behavioral health and substance use disorder outpatient office visits \$5 \$15 \$15 Westall/behavioral health and substance use disorder outpatient direns and services \$5 \$15 \$15 Pregnancy Pregnancy Presultal care and preconception visits No charge No charge Pregnancy Presultal care and preconception visits No charge No charge Vialid and viality of the properties of the presults		Tier 4				
Comparison Com		Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient visit Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge Emergency room physician fee (waived if admitted) Urgent care Urgent care Hospital stay Hospital		Physician/surgeon fees	10%		15%	
Emergency room facility fee (walved if admitted) Sign	services	Outpatient visit	10%		15%	
Needata Emergency room physician fee (waived if admitted) No charge \$30 \$75 \$1						
immodiate attention Medical transportation (including emergency and non-emergency) S30 S75 S15 Facility fee (e.g. hospital roam) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee 10% Mental health, and substance use disorder outpatient office behavioral health, or substance substance abuse needs Pregnancy Prenatal care and preconception vists No charge Hende health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stilled nursing care Child sys care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Child Dental Basic Services Child Dental Basic Services Crowns and Casts Enclodoritics Child Dental Major Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Child Dental Precodures Precoduring or Cast Service Child Dental Basic Service Child Dental Park Control Cast Services Crowns and Casts Encodoritics Precidential Major Services Child Dental Processing Precidential Major Services Control Services Child Dental Park Control Cast Services Control Services Control Cast Service Child Dental Park Control Cast Services Crowns and Casts Encodoritics Precidential Major Services Control Servi	Need					
Urgent care Bacility face (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health, pehavioral health and substance use disorder outpatient office values media. Mental health, behavioral health and substance use disorder outpatient office values media. Mental/behavioral health and substance use disorder outpatient office values media. Mental/behavioral health and substance use disorder outpatient office values media. Mental/behavioral health and substance use disorder outpatient items and services. Mental/behavioral health and substance use disorder outpatient items and services. Mental/behavioral health and substance use disorder outpatient items and services. Mental/behavioral health and substance use disorder outpatient items and services. Mental/behavioral health and substance use disorder outpatient office values. Mental/behavioral health and substance use disorder outpatient office values. Mental/behavioral health and substance use disorder outpatient office values. Mental/behavioral health and substance use disorder outpatient office values. Mental/behavioral health and substance use disorder outpatient office value. Sist of the substance of the substance use disorder outpatient office value. Sist of the substance use disorder outpatient office value. Sist of the substance outpatient outpatient outpatient office value. Sist of the substance outpatient outpatient outpatient office value. Sist of the substance outpatient outpatient outpatient office value. Sist of the substance outpatient outpatient outpatient office value. Sist of the substance outpatient outpatient outpatient outpatient office value. Sist of the substance outpatient outpatient outpatient outpatient outpatient outpatient outpatient office value. Sist of the substance outpatient out	immediate		_		, and the second	
Hospital stay Physician/sugeon fee Hospital stay Physician/sugeon fee Hospital stay Physician/sugeon fee Hospital health, and substance use disorder outpatient office visits Mental health, behavioral health and substance use disorder outpatient office visits Mental health, behavioral health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient office visits Mental health and substance use disorder outpatient	attention					
Hospital stay A		-	\$5		\$15	
Montal health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient diters and services Mental/behavioral health and substance use disorder other outpatient diters and services Mental/behavioral health and substance use disorder other outpatient diters and services Mental/behavioral health and substance use disorder other outpatient S5 \$15 S15 Pregnancy Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care 10% X 15% X 15% X Durable medical equipment Hospice service Preventive - Clearing Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Child Dental Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Mot Covered Not Covered	Hospital stay	delivery, mental health, and substance use)		Х		Χ
behavioral health, or substance abuse needs Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services S5 S15 S15 Precovering or other special health needical equipment Hospice service Child eye care Child eye care Child pertail Preventive - Cleaning		Physician/surgeon fee	10%		15%	
Pregnancy Prenatal care and preconception visits No charge No charge	behavioral	·	\$5		\$15	
Home health care (cost share per visit) Help recovering or other special health care (cost share per visit) Outpatient Rehabilitation and Habilitation services SS \$15 Skilled nursing care 10% X 15% X Durable medical equipment 10% No charge No charge Child eve care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Child Dental Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Major Services Child Dental Majo		·	\$5		\$15	
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child exam Preventive Child Dental Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Major Services	Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Skilled nursing care other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services Child Dental Major Services Skilled nursing care 10% X 15% X 15% No charge No ch		Home health care (cost share per visit)	\$3		\$15	
Skilled nursing care 10%	Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pagessary orthodontics Oral Surgery Child Medically pagessary orthodontics Not Covered	recovering or	Skilled nursing care	10%	X	15%	Х
Hospice service Child eye care Eye exam I pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive and Preventive Child Dental Basic Services Child Dental Basic Services Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Dental Madically presses any orthodontics Oral Surgery Child Madically presses any orthodontics Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered		·				
Child eye care Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Prosthodontics Prosthodontics Oral Surgery Child Medically penessary orthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered						
Child Dental Basic Services Child Dental Basic Services Child Dental Major Services Coral Surgery Child Medically necessary orthodortics Not Covered			_		•	
Preventive - Cleaning Preventive - Strain Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Prosthodontics Oral Surgery Child Medically peressary orthodontics Oral Medically peressary orthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Child eye care		_		_	
Child Dental Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered		Oral Exam				
Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered		Preventive - Cleaning				
and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered Not Covered Not Covered Not Covered		Preventive - X-ray	N . 2			
Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered Not Covered Not Covered		Sealants per Tooth	Not Covered		Not Covered	
Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered Not Covered		Topical Fluoride Application				
Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered Not Covered						
Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered Not Covered Not Covered	Child Dantal					
Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered			Not Covered		Not Covered	
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered						
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered						
Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered Not Covered	Child Dental		Not O		Net Carra	
Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered	Major Services		Not Covered		NOT Covered	
Child Medically necessary orthodontics Not Covered Not Covered						
	OL V	Oral Surgery				
		Medically necessary orthodontics	Not Covered		Not Covered	

Summary	of Ranafite	and Coverage	

•	nefits and Coverage	Silver Plan	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	-
Actuarial Value - A		73.9% <u>73.6%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 / \$275 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$550 / \$	
	Individual Out-of-pocket maximum	\$6,500	o .
	Family Out-of-pocket maximum	\$13,000	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's office or clinic	Other practitioner office visit	\$35	
visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmacy deductible
Drugs to treat	Tier 2	\$55	Pharmacy
illness or condition	Tier 3		deductible Pharmacy
Condition	Hel 3	\$85 20% up to \$250 per script	deductible Pharmacy
	Tier 4	after pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	200/	V
Hospital stay	delivery, mental health, and substance use)	20%	X
	Physician/surgeon fee	20%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
recovering or	Skilled nursing care	20%	X
other special health needs	Durable medical equipment	20%	• •
	Hospice service	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child David	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services		
	Crowns and Casts		
a 1	Endodontics		
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

9.5 EHB

Summary	of Ron	ofite and	Coverage	

-	nefits and Coverage			Bronze	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		HDHP Plan	
Actuarial Value - AV Calculator		61.4% <u>64.71%</u>		62.1% <u>64.6%</u>	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, integrated	
Integrated Individual deductible		N/A		\$6,900 <u>\$7,000</u> integrated	
Integrated Family deductible		N/A		\$13,800 <u>\$14,000</u> integrated	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,300 / \$500 <u>\$750</u> / \$0 \$12,600 / \$1,000 \$1,500 / \$0		N/A N/A	
Family deductible, NOT integrated: wedical / Pharmacy / Dental Individual Out–of–pocket maximum		\$12,500 / \$1,000 \$1, <u>500</u> / \$0 \$ 7,800 \$ <u>7,950</u>		See endnote	
	Family Out-of-pocket maximum	\$15,600\$15,900		See endnote	
	HSA plan: Self-only coverage deductible	N/A		\$ 6,900 \$7,000	
	HSA family plan: Individual deductible			\$6,900 <u>\$7,000</u>	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$65 <u>\$95</u>	After 1st three non- preventive visits	0%	х
provider's office or clinic	Other practitioner office visit	\$ 6 5 <u>\$95</u>	After 1st three non- preventive visits	0%	X
visit	Specialist visit	\$95 <u>\$125</u>	After 1st three non- preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40	X	0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	Х
	Imaging (CT/PET scans, MRIs)	40%	X	0%	Х
	Tier 1	\$18	Pharmacy Deductible	0%	Х
December 1	Tier 2	40% up to \$500 per script after	Pharmacy	0%	x
Drugs to treat illness or	1012	pharmacy deductible	Deductible	U%	^
condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
	Tier 4	40% up to \$500 per script after	Pharmacy Deductible	0%	X
	Surgery facility fee (e.g., ASC)	pharmacy deductible 40%	Z	0%	X
Outpatient	Physician/surgeon fees	40%	X	0%	X
services		40%	X	0%	×
	Outpatient visit				
Need	Emergency room facility fee (waived if admitted)	40%	X	0%	X
immediate	Emergency room physician fee (waived if admitted)	No charge		0%	X
attention	Medical transportation (including emergency and non-emergency)	40%	X After 1st three non-	0%	X
	Urgent care	\$65 <u>\$95</u>	preventive visits	0%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	X
. ,	Physician/surgeon fee	40%	X	0%	Х
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$65 <u>\$95</u>	After 1st three non- preventive visits	0%	Х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$6 5 <u>\$95</u>	×	0%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	Х	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	\$65 <u>\$95</u>		0%	Х
recovering or other special	Skilled nursing care	40%	×	0%	X
health needs	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	X
	Eye exam	No charge		No charge	^
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	. to only o		o onargo	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic		Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	Not Covered		Not Covered	
Dudic del Vices	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Summary of Benefits and Coverage

Summary or Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Catast	trophic Plan
Actuarial Value - A	V Calculator		
Plan design includes a deductible?		Yes, integrated	
Integrated Individual deductible		\$8,150 <u>\$8,300</u> integrated	
	Integrated Family deductible	\$16,300 <u>\$1</u>	6,600 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A \$ 8,150 \$8,300	
Individual Out–of–pocket maximum Family Out-of-pocket maximum			
HSA plan: Self-only coverage deductible			
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three non- preventive visits
office or clinic	Specialist visit	0%	X
Viole	'		^
	Preventive care/ screening/ immunization Laboratory Tests	No charge 0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
30.0	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
Drugs to treat	Tier 2	0%	×
illness or condition	Tier 3	0%	X
		0,0	
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient services	Physician/surgeon fees	0%	×
Sel Vices	Outpatient visit	0%	×
	Emergency room facility fee (waived if admitted)	0%	Х
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	0%	X
	Urgent care	0%	After 1st three non-
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		preventive visits
Hospital stay	delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	×
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
	Eye exam	No charge	^
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam	0 70	^
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	Not Covered	
Dasic Services	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts		
	Endodontics		
	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

Endnotes to Covered California <u>2020-2021</u> Patient-Centered Benefit Plan Designs

These endnotes and the Patient-Centered Benefit Plan Designs apply only to covered services.

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 20202021 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a

- service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 19) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
- 20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
- 21) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.
- 22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
- 23) Drug tiers are defined as follows:

Tier	Definition		
1	1) Most generic drugs and low cost preferred brands.		
	1) Non-preferred generic drugs;		
2	2) Preferred brand name drugs; and		
	3) Any other drugs recommended by the plan's		
	pharmaceutical and therapeutics (P&T) committee based on		
	drug safety, efficacy and cost.		
3	1) Non-preferred brand name drugs or;		
	Drugs that are recommended by P&T committee based		
	on drug safety, efficacy and cost or;		
	Generally have a preferred and often less costly		
	therapeutic alternative at a lower tier.		
4	Drugs that are biologics and drugs that the Food and		
	Drug Administration (FDA) or drug manufacturer requires to		
	be distributed through specialty pharmacies;		
	2) Drugs that require the enrollee to have special training or		
	clinical monitoring;		
	3) Drugs that cost the health plan (net of rebates) more than		
	six hundred dollars (\$600) net of rebates for a one-month		
	supply.		

Some drugs may be subject to zero cost-sharing under the preventive services rules.

24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The Bronze and Bronze HDHP is are contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2020-2021 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.