Covered California 2019 2020 Patient-Centered Benefit Plan Designs¹

Final Board-approved Proposed March 15, 2018 March 14, 2019

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

10.0 EHB Date: March 15, 2018 March 14, 2019

Summary of Benefits and Coverage



Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinum Coinsurance Plan		Platinum Copay Plan	
Actuarial Value -	AV Calculator	91.7%	i idii	88.9 <u>89.1</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	\$3,350 <u>\$4.5</u>	<u>00</u>	\$3,350 <u>\$4,500</u>	
	Family Out-of-pocket maximum	\$ 6,700 \$9,0	<u>00</u>	\$ 6,700 \$9,000	
	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	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	On a similar winter	# 00		# 00	
CHILIC 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	Tier 2	\$15		\$15	
Drugs to treat illness		ΨΙΟ			
or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	Surgery facility fee (e.g., ASC)	script		script \$100	
Outpatient	Physician/surgeon fees				
services		10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
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 delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$15		\$15	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	itams and carvious	\$15		\$15	
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	
recovering o	Skilled pursing care	10%		\$150 per day up to	
other special health needs				5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
ouro	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			30	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	200/		See 20192020	
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule	
	Crowns and Casts				
Oh'' I D	Endodontics			0001005	
Child Dental Major	Periodontics (other than maintenance)	50%		See 20192020 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics	Wododily Hoodsally Orthodolitics	30 %		φ1,000	

ember Cost Sha	re amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
ctuarial Value -	AV Calculator	81.8 <u>81.9</u> %		78.1 <u>78.3</u> %	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 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0/\$0/\$	
	Individual Out-of-pocket maximum	\$7,200 <u>\$7,85</u>		\$7,200 <u>\$7,8</u>	
	Family Out-of-pocket maximum	\$14,400 <u>\$15,7</u> N/A	<u>'00</u>	\$14,400 <u>\$15,</u> N/A	<u>700</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A		N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
Event	Primary care visit to treat an injury, illness, or condition	\$30	Дрисо	\$30	/ фріі
Health care					
provider's office or	Other practitioner office visit	\$30		\$30	
clinic visit	Specialist visit	\$55 <u>\$60</u>		\$55 <u>\$60</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35 <u>\$40</u>		\$35 <u>\$40</u>	
Tests	X-rays and Diagnostic Imaging	\$55 <u>\$75</u>		\$55 <u>\$75</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
	Tier 2				
Drugs to treat illness or condition	Hel Z	\$55		\$55	
	Tier 3	\$75 <u>\$80</u>		\$75 <u>\$80</u>	
	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	
30. 1.000	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$ 325 \$350		\$ 325 \$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care			\$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)	20%		5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral health, or	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 o		20%		\$300 per day up to 5 days	
health needs		20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	140 onargo		140 onargo	
	Preventive - Cleaning				
Child Dental	· ·				
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
01.11.5	Space Maintainers - Fixed			0	
Child Dental Basic	Restorative Procedures	20%		See 20192020 Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2019 2020	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				

	mounts describe the Enrollee's out of pocket costs.	Gold			
	The state of the s	Coinsurance Plan	1	Gold Copay Plan	
Actuarial Value - AV Calculator		81.878.1%		78.179.7 %	
	Plan design includes a deductible?	NeYes, Medical/Pharn	nacv	NeYes, Medical/Pha	rmacv
	Integrated Individual deductible	\$0 <u>N/A</u>	<u></u>	\$0 <u>N/A</u>	<u>maoy</u>
	Integrated Family deductible	\$ <u>0</u> N/A		\$0N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$250</u> / \$0 / \$0		\$0 <u>\$250</u> / \$0 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$500</u> / \$0 / \$0		\$0 <u>\$500</u> / \$0 / \$0	0
	Individual Out-of-pocket maximum	\$7,200 <u>\$7,850</u>		\$7,200 <u>\$7.850</u>	
	Family Out-of-pocket maximum	\$14,400 <u>\$15,700</u>		\$14,400 <u>\$15,70</u> 0	<u>0</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	\$3 0 <u>\$25</u>		\$30 <u>\$25</u>	
Health care provider's	Other practitioner office visit	\$30 \$2 <u>5</u>		\$30 \$25	
office or	·	_			
clinic visit	Specialist visit	\$55 <u>\$50</u>		\$55 <u>\$50</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35 <u>\$25</u>		\$35 <u>\$25</u>	
Tests	X-rays and Diagnostic Imaging	\$55 <u>\$65</u>		\$55 <u>\$65</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$55 <u>\$50</u>		\$55 <u>\$50</u>	
treat illness or condition	Tier 3	\$75 <u>\$80</u>		\$75 <u>\$80</u>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outnationt	Physician/surgeon fees	20%			
services				\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325 <u>\$250</u>	X	\$325 <u>\$250</u>	<u>X</u>
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$250	<u>X</u>	\$250	<u>X</u>
	Urgent care	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	X
nospital stay	Physician/surgeon fee	20%	<u>X</u>	No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
hoolth	visits	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
health, or	Mental/behavioral health and substance use disorder other outpatient				
	items and services	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20% \$30		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
recovering or	Skilled nursing care	20%	<u>X</u>	\$300 per day up to 5 days	<u>X</u>
health needs			△		<u> </u>
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
care	Eye exam	No charge		No charge	
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	No oborgo		No oborgo	
and	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Restorative Procedures			Son 20102020 D+-1 0	
Basic	Periodontal Maintenance Services	20%		See 20192020 Dental Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 20192020 Dental Copay	
Major Services	Periodontics (other than maintenance)	50%		Schedule Schedule	
	Prosthodontics				
	Oral Surgery				
Child		50%		\$1,000	

Summary of Benefits and Coverage	Summary	of Benefits and Covera	ae
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Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver Plan
Actuarial Value - A	V Calculator	71.8 <u>71.7</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	\$ 2,500 \$4,000 / \$ 200 \$300 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<u>\$5,000</u> \$8,000 / \$400 <u>\$600</u> / \$0
	Individual Out-of-pocket maximum	\$7,55 0 <u>\$7,850</u>
	Family Out-of-pocket maximum	\$15,100 <u>\$15,700</u>
	HSA plan: Self-only coverage deductible	N/A
	HSA family plan: Individual deductible	N/A
Common		Deductible

Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests K-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3	\$40 \$40 \$80 No charge \$35\$40 \$75\$85 \$300\$325 \$15\$16 \$55\$60	Pharmacy deductible Pharmacy deductible
Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests (-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1	\$40 \$80 No charge \$35 <u>\$40</u> \$75 <u>\$85</u> \$300 <u>\$325</u> \$15 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
Specialist visit Preventive care/ screening/ immunization aboratory Tests K-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Fier 1	\$80 No charge \$35 <u>\$40</u> \$75 <u>\$85</u> \$300 <u>\$325</u> \$45 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
Preventive care/ screening/ immunization Laboratory Tests K-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Fier 1 Fier 2	No charge \$35 <u>\$40</u> \$75 <u>\$85</u> \$300 <u>\$325</u> \$15 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
Preventive care/ screening/ immunization Laboratory Tests K-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Fier 1 Fier 2	No charge \$35 <u>\$40</u> \$75 <u>\$85</u> \$300 <u>\$325</u> \$15 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
Laboratory Tests K-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Tier 1 Tier 2	\$35 <u>\$40</u> \$75 <u>\$85</u> \$300 <u>\$325</u> \$15 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
K-rays and Diagnostic Imaging maging (CT/PET scans, MRIs) Fier 1 Fier 2 Fier 3	\$75 <u>\$85</u> \$300 <u>\$325</u> \$15 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
maging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3	\$300 <u>\$325</u> \$15 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
Tier 1 Tier 2 Tier 3	\$15 <u>\$16</u> \$55 <u>\$60</u>	deductible Pharmac
Tier 2	\$55 <u>\$60</u>	Pharmad
Tier 3	_	
	\$80 \$90	
Tier 4	\$55 <u>\$55</u>	Pharmac deductible
	20% up to \$250 per script	Pharmac
2 (after pharmacy deductible	deductible
Surgery facility fee (e.g., ASC)	20%	
		
	_	
		X
	\$40	
delivery, mental health, and substance use)	20%	Х
Physician/surgeon fee	20%	
Mental/behavioral health and substance use disorder outpatient office isits	\$40	
Mental/behavioral health and substance use disorder other outpatient tems and services	\$40	
Prenatal care and preconception visits	No charge	
Home health care (cost share per visit)	\$45	
Outpatient Rehabilitation and Habilitation services	\$40	
Skilled nursing care	20%	X
,	_	
Oral Exam	The change	
Preventive - Cleaning		
Preventive - X-ray		
	No charge	
Space Maintainers - Fixed		
Restorative Procedures		
Periodontal Maintenance Services	20%	
Crowns and Casts		
Endodontics		
Periodontics (other than maintenance)	50%	
Prosthodontics		
Dral Surgery		
	50%	
	Internal/behavioral health and substance use disorder outpatient office isits Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder outpatient outpatient ems and services Idental/behavioral health and substance use disorder outpatient of ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient ems and services Idental/behavioral health and substance use disorder other outpatient Idental/b	Dutpatient visit Dimergency room physician fee (waived if admitted) No charge ledical transportation (including emergency and non-emergency) S250 Irrgent care S40 Salosystop S250 Irrgent care S40 Salosystop S40 S40 S40 S40 S40 S40 S40 S4

Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Plan design includes a deductible? Plan design includes a deductible N/A Integrated Individual deductible N/A Integrated Family deductible N/A N/A N/A N/A N/A N/A N/A N/A	Plan <mark>2</mark> % Pharmacy
Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy Yes, Medical/Pharmacy Yes, Medical/Pharmacy Yes, Medical/Pharmacy N/A N/A Integrated Family deductible N/A N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$2,000\$\frac{5}{2,000}\$\frac{5}{2,250}\$ / \$200\$\frac{5}{300}\$ / \$0 \$2,000\$\frac{5}{2,250}\$ / \$200\$\frac{5}{2,000}\$ / \$200\$\frac{5}{	Pharmacy
Integrated Individual deductible N/A N/A N/A N/A Integrated Family deductible N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$2,000\$\frac{\\$2,000}{\\$2,250}\$ / \\$200\$\frac{\\$300}{\\$200}\$ / \\$0 \$2,000\$\frac{\\$2,000}{\\$2,250}\$ /	·
Integrated Family deductible N/A N/A N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$2,000\\$2,250 / \\$200\\$300 / \\$0 \\$2,000\\$2,250 /	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$2,000\\$2,250 / \\$200\\$300 / \\$0 \$2,000\\$2,250 /	
	200<u>\$300</u> / \$0
Family deductible NOT integrated: Medical / Dearmons / Deartal #4 00004 500 / 600	
	4 00 <u>\$600</u> / \$0
Individual Out-of-pocket maximum \$7,550\frac{\frac{1}{27,550}}{27,850} \$7,550\frac{\frac{1}{27,550}}{27,850} \$7,550\frac{\frac{1}{27,550}}{27,850} \$7,550\frac{\frac{1}{27,550}}{27,850} \$7,550\frac{\frac{1}{27,550}}{27,850} \$7,550\frac{\frac{1}{27,550}}{27,850} \$7,850\frac{\frac{1}{27,550}}{27,850}	
Family Out-of-pocket maximum \$15,700 \$15,700 HSA plan: Self-only coverage deductible N/A N/A	
HSA family plan: Individual deductible N/A N/A	
Common Medical Service Type Member Cost Share Deductible Applies Member Cost Share	Deductible Applies
Primary care visit to treat an injury, illness, or condition \$45 <u>\$50</u> \$45 <u>\$50</u>	
Health care provider's Other practitioner office visit \$45\\$50 \$45\\$50	
office or \$80\$85 \$80\$85	
Preventive care/ screening/ immunization No charge No charge	
Laboratory Tests \$40 \$40	
Tests X-rays and Diagnostic Imaging \$75\\$85 \$75\\$85	
Imaging (CT/PET scans, MRIs) 20% \$300	
Tier 1 S15S17 Pharmacy S15S17	Pharmacy
\$19 <u>\$17</u> deductible \$19 <u>\$17</u>	deductible
Drugs to Tier 2 \$55\\$65 Pharmacy deductible \$55\\$65	Pharmacy deductible
treat illness or condition Tier 3 Pharmacy deductible \$85\$90 \$90 deductible	Pharmacy deductible
20% up to \$250 per script after. Pharmacy, 20% up to \$250 per script	
Tier 4 pharmacy deductible pharmacy deductible deductible pharmacy deductible	
Surgery facility fee (e.g., ASC) 20% 20%	
Outpatient services Physician/surgeon fees 20% 20%	
Outpatient visit 20% 20%	
Emergency room facility fee (waived if admitted) \$359 <u>\$400</u> <u>X</u> \$359 <u>\$400</u>	<u>X</u>
Need 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 \$45\subsection 50	
Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Year-ite attractions and delivery, mental health, and substance use)	X
Hospital stay Physician/surgeon fee 20% X 20%	
Mental Mental/behavioral health and substance use disorder outpatient office	
health, visits \$45\frac{\$50}{}	
health, or substance abuse needs Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services \$45\sum_{50}	
Pregnancy Prenatal care and preconception visits No charge No charge	
Home health care (cost share per visit) 20% \$45	
Help Outpatient Rehabilitation and Habilitation services \$45\frac{\$50}{2}\$	
recovering or Skilled pursing care	X
other special health needs health needs Durable medical equipment 20% 20% 20%	
Evo over	
Child eye Eye exam No charge No charge Care 1 pair of classes per year (or contact lenses in lieu of classes) No charge	
1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge	
Preventive - Cleaning Child Dental Preventive - X-ray	
Diagnostic and Sealants per Tooth No charge No charge	
Preventive Sealants per Tooth	
Topical Fluoride Application	
Space Maintainers - Fixed Child Dental Restorative Procedures	
Basic 20% See 2019 2020 Dental C	opay
Services Periodonial Maintenance Services	
Crowns and Casts	
Child Dental Major Periodentics (other than maintanance) See 20192020 Dental C	opav
Services Schedule	-1-7
Prosthodontics	
Oral Surgery	
Child Orthodontics Medically necessary orthodontics 50% \$1,000	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB <u>-o</u> Silver HDHP P	
ctuarial Value - A	V Calculator	70.5 <u>71.3</u>	
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$2,500 integ	grated
	Integrated Family deductible	\$5,000 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$6,650 <u>\$6</u> ,	<u>850</u>
	Family Out-of-pocket maximum	\$13,300 <u>\$1</u> :	<u>3,700</u>
	HSA plan: Self-only coverage deductible	\$2,500	
	HSA family plan: Individual deductible	See endr	ote
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	20%	X
Health care provider's	Other practitioner office visit	20%	X
office or clinic visit	Specialist visit	20%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	X
Tests	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	×
	Tier 1	20% up to \$250 per script	X
Drugs to	Tier 2	20% up to \$250 per	X
treat illness or condition	Tier 3	script 20% up to \$250 per	×
	Tier 4	script 20% up to \$250 per	X
		script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees	20%	X
	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	X
Need immediate	Emergency room physician fee (waived if admitted)	0%	X
attention	Medical transportation (including emergency and non-emergency)	20%	X
	Urgent care	20%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	x
Mental		2076	X
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	items and services	20%	Х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	X
Help	Outpatient Rehabilitation and Habilitation services	20%	X
recovering or other special	Skilled nursing care	20%	X
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		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
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	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
ctuarial Value - A	V Calculator	94.294.		87.987.7%	
	Plan design includes a deductible?	Yes, Medical/F		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	\$75 / \$0	/ \$0	\$650 <u>\$1,400</u> / \$50 <u>\$100</u>	<u>)</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0 / \$0		\$1,300 <u>\$2.800</u> / \$100 <u>\$200</u> / \$0	
	Individual Out-of-pocket maximum	\$1,000	0	\$2,600 <u>\$2,700</u>	
	Family Out-of-pocket maximum	\$2,000	0	\$ 5,20 0 <u>\$5,400</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	Other practitioner office visit	\$5		\$15	
office or clinic visit	Cutor practition clinic viola	Ψ		ΨΙΟ	
	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$15 <u>\$20</u>	
Tests	X-rays and Diagnostic Imaging	\$8		\$30 \$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Drugs to	Tier 2	\$10		\$ 20 \$25	Pharmad deductible
treat illness or condition	Tier 3	\$15		\$35 <u>\$45</u>	Pharmad
				_	deductib
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmac deductible
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
501 11000	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$100 <u>\$150</u>	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$30	×	\$75	X
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	ψ3		ΨΙΟ	
Hospital stay	delivery, mental health, and substance use)	10%	X	15%	Х
	Physician/surgeon fee	10%		15%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or 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	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	15%	Х
other special health needs	Durable medical equipment	10%	-	15%	••
	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				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services	ZU70		2070	
	Crowns and Casts				
01.11.5	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
				I .	
	Oral Surgery				

Common Medical	Service Type	Member Cost Share Deductible Applies
	HSA family plan: Individual deductible	N/A
	HSA plan: Self-only coverage deductible	N/A
	Family Out-of-pocket maximum	\$ 12,600 <u>\$13,100</u>
	Individual Out-of-pocket maximum	\$6,300 <u>\$6.550</u>
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 4,400 \$ <u>7,400</u> / \$ 350 \$ <u>550</u> / \$0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 2,200 \$3,700 / \$ 175 <u>\$275</u> / \$0
	Integrated Family deductible	N/A
	Integrated Individual deductible	N/A
	Plan design includes a deductible?	Yes, Medical/Pharmacy
Actuarial Value - A	AV Calculator	73.9 73.8%
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL
Summary of Be	enefits and Coverage	

	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	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35 <u>\$40</u>	
Tests	X-rays and Diagnostic Imaging	\$75 <u>\$85</u>	
	Imaging (CT/PET scans, MRIs)	\$300 <u>\$325</u>	
	Tier 1	\$15 \$1 <u>6</u>	Pharmac
			deductib Pharma
Drugs to treat illness	Tier 2	\$50 <u>\$55</u>	deductib
or condition	Tier 3	\$75 <u>\$85</u>	Pharmad deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
0.40.45.04	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350 <u>\$400</u>	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	X
	Urgent care	\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х
	Physician/surgeon fee	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
health, or 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 other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	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	No oborgo	
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	2070	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

lember Cost Shar	e amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	
ctuarial Value -	AV Calculator	60.9 <u>61.3</u> %		61.6 62.0	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy	Yes, integra	ated
	Integrated Individual deductible	N/A		\$6,000 <u>\$6,950</u> in	
	Integrated Family deductible	N/A		\$ 12,000 \$13,900 i	integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	60	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 /	\$0	N/A	
	Individual Out-of-pocket maximum	\$ 7,550 \$ <u>7,850</u>		\$6,650 <u>\$6,9</u>	<u>950</u>
	Family Out-of-pocket maximum	\$15,100 <u>\$15,700</u>	<u>)</u>	\$13,300 <u>\$13</u>	,900
	HSA plan: Self-only coverage deductible	N/A		\$6,000 <u>\$6.9</u>	<u>950</u>
	HSA family plan: Individual deductible	HSA family plan: Individual deductible N/A \$6,000 <u>\$6</u> .		\$ 6,000 <u>\$6,9</u>	<u>950</u>
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$75 \$65	After 1st three non-	40% 0%	Х
Health care		_	preventive visits After 1st three non-		
provider's office or	Other practitioner office visit	\$75 <u>\$65</u>	preventive visits	40% 0%	X
clinic visit	Specialist visit	\$105 <u>\$95</u>	After 1st three non- preventive visits	40% <u>0%</u>	X
	Preventive care/ screening/ immunization	No charge	,	No charge	
	Laboratory Tests	\$40		40% 0%	Х
Tests	X-rays and Diagnostic Imaging	100% 40%	Х	40% 0%	X
	Imaging (CT/PET scans, MRIs)	100% 40%	X	4 0% 0%	X
		4000/ to \$500		40% up to \$500	
	Tier 1	pharmacy deductible \$18	Pharmacy Deductible	per script0%	X
Drugs to	Tier 2	400%40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script0%	X
treat illness or condition	Tier 3	100%40% up to \$500 per script after	Pharmacy	40% up to \$500	
or condition	Tiel 3	pharmacy deductible	Deductible	per script0%	X
	Tier 4	100%40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script0%	Х
	Surgery facility fee (e.g., ASC)	100%40%	X	4 0% 0%	X
Outpatient	Physician/surgeon fees		X	4 0% 0%	X
services		100% <u>40%</u>			
	Outpatient visit	100% 40%	X	40% 0%	X
Need immediate	Emergency room facility fee (waived if admitted)	100% <u>40%</u>	X	40% 0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
attention	Medical transportation (including emergency and non-emergency)	100% 40%	X	40% <u>0%</u>	Х
	Urgent care	\$75 <u>\$65</u>	After 1st three non- preventive visits	4 0% 0%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100% 40%	×	40% 0%	Х
Hospital stay	delivery, mental health, and substance use)		V	_	
Mantal	Physician/surgeon fee	100% <u>40%</u>	X	40% 0%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$75 <u>\$65</u>	After 1st three non- preventive visits	40% 0%	Х
behavioral health, or			proventive violes		
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$75 <u>\$65</u>	X	40% 0%	Х
abuse needs					
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	100% 40%	X	40% 0%	X
Help	Outpatient Rehabilitation and Habilitation services	\$75 <u>\$65</u>		4 0% 0%	X
recovering or other special	Skilled nursing care	100% <u>40%</u>	X	40% 0%	X
health needs	Durable medical equipment	100% <u>40%</u>	X	4 0% 0%	Х
	Hospice service	No charge		0%	X
Child	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	
		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	Restorative Procedures			222/	
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	, ,	JU70		JU /0	
	Prosthodontics				
01.11	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

-	nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan
Actuarial Value - A			
	Plan design includes a deductible?		integrated
	Integrated Individual deductible Integrated Family deductible		6,400 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	ψ.ο,οσο <u>ψ.</u>	N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	\$7, 9	900 <u>\$8,200</u>
	Family Out-of-pocket maximum	\$15, 8	3 00 <u>\$16,400</u>
	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
Lvent	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 visit	Specialist visit	0%	· ×
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1		
	nor I	0%	X
Drugs to treat illness	Tier 2	0%	X
or condition	Tier 3	0%	Х
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient services	Physician/surgeon fees	0%	×
	Outpatient visit	0%	×
	Emergency room facility fee (waived if admitted)	0%	X
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- preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	X
Mental	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-
health, behavioral	visits	0%	preventive visits
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	x
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	×
recovering or	Skilled nursing care	0%	X
other special 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		
	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%	X
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	0%	X
Services	Prosthodontics		
	Oral Surgery		
Child			

Medically necessary orthodontics

0%

Х

Date: March 15, 2018 March 14, 2019

Summary of Benefits and Coverage



	amounts describe the Enrollee's out of pocket costs.	Platinum		Platinum	
Actuarial Value - A\		Coinsurance 91.7%	Plan	Copay Pla 88.989.19	
Actuariai value - Av					0
	Plan design includes a deductible?	No \$0		No \$0	
	Integrated Individual deductible Integrated Family deductible	\$0 \$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/\$	
	Individual Out-of-pocket maximum	\$ 3,350 \$4,5		\$ 3,350 \$4,5	
	Family Out-of-pocket maximum	\$6,700 \$9,0		\$ 6,700 \$9,0	
	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	
Health care	Other practitioner office visit	04 5		645	
provider's office or	Other practitioner office visit	\$15		\$15	
clinic 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	
	Time			A .=	
Drugs to treat illness or	Tier 2	\$15		\$15	
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	Her 4	script		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,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
behavioral health, or	visits				
substance abuse needs	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)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days	
health needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
Child	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	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services			55vorou	
	Crowns and Casts				
Child Daniel	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics		140t Govereu		110t Govereu	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	-
ctuarial Value - A	V Calculator	81.8 <u>81.9</u> %		78.1 <u>78.3</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 / \$	
	Individual Out-of-pocket maximum	\$7,200 <u>\$7,85</u>		\$ 7,200 \$ <u>7,8</u>	
	Family Out-of-pocket maximum	\$14,400 <u>\$15,7</u> N/A	<u>700</u>	\$14,400 <u>\$15,</u> N/A	<u>700</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A		N/A	
Common	Service Type	Member Cost	Deductible	Member Cost	Deductib
Medical Event	Primary care visit to treat an injury, illness, or condition	Share \$30	Applies	Share \$30	Applies
Health care provider's	Other practitioner office visit	\$30		\$30	
office or clinic visit	Specialist visit	\$ 5 5 <u>\$60</u>		\$ 5 5 <u>\$60</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35 \$40		\$35 \$40	
Tests	X-rays and Diagnostic Imaging	\$55 \$75		\$55 \$75	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Orugs to treat	Tier 2	\$55		\$55	
Ilness or condition	Tier 3	\$75 <u>\$80</u>		\$75 <u>\$80</u>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient	Physician/surgeon fees	20%		\$40	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325 <u>\$350</u>		\$325 \$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
mmediate 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			\$600 per day up to	
Hospital stay	delivery, mental health, and substance use)	20%		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	
ecovering 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 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
		No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Obilet D	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

-	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		81.8 <u>78.1</u> %		78.1 <u>79.7</u> %	
	Plan design includes a deductible? Integrated Individual deductible	Ne <u>Yes, Medical/Pharr</u> \$0 <u>N/A</u>	<u>macy</u>	Ne <u>Yes, Medical/Pha</u>	rmacy
	Integrated Family deductible	\$0 <u>N/A</u>		\$0 <u>N/A</u>	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$250</u> / \$0 / \$0		\$0 \$250 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 0 \$500 / \$0 / \$0		\$0 <u>\$500</u> / \$0 / \$	0
	Individual Out-of-pocket maximum	\$7,200 <u>\$7,850</u>		\$7,200 <u>\$7,850</u>	
	Family Out-of-pocket maximum	\$14,400 <u>\$15,700</u>		\$14,400 <u>\$15,70</u>	<u>0</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		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	\$30 \$25		\$30 \$25	
Health care provider's	Other practitioner office visit	\$30 \$25		\$30 <u>\$25</u>	
office or					
clinic visit	Specialist visit	\$55 <u>\$50</u>		\$55 <u>\$50</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
Tooto	Laboratory Tests	\$35 <u>\$25</u>		\$35 <u>\$25</u>	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$55 <u>\$65</u>		\$55 <u>\$65</u>	
	, ,	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat illness or	Tier 2	\$5 5 <u>\$50</u>		\$ 5 5 <u>\$50</u>	
condition	Tier 3	\$75 <u>\$80</u>		\$75 <u>\$80</u>	
	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	
301 11003	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325 <u>\$250</u>	<u>x</u>	\$325 <u>\$250</u>	<u>X</u>
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	<u>x</u>	\$250	<u>X</u>
	Urgent care	\$30 \$25	_	\$30 <u>\$25</u>	_
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	<u>X</u>	\$600 per day up to 5 days	<u>×</u>
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X	No charge	Δ
Mental health.	Mental/behavioral health and substance use disorder outpatient office		Δ	-	
behavioral health, or	visits	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20% \$30		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
recovering or	Skilled nursing care	20%	<u>x</u>	\$300 per day up to 5 days	<u>x</u>
other special health needs	Durable medical equipment	20%	_	20%	<u>~</u>
	Hospice service				
	Eye exam	No charge		No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge No charge		No charge No charge	
	Oral Exam	140 Charge		140 Charge	
	Preventive - Cleaning				
Child Dental	Preventive - Cleaning Preventive - X-ray				
Diagnostic and		Not Covered		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child	Oral Surgery Medically peoples any orthodoxtics	Not Covered		Not Covered	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of	Benefits and	Coverage

	enits and Coverage amounts describe the Enrollee's out of pocket costs.	<u>Individual-only</u> Silve	Plan
ctuarial Value - A\	/ Calculator	71.8<u>71.7</u>%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 2,500 \$4,000 / \$ 200 \$3	<u>00</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<u>\$5,000</u> \$8,000 / \$400 <u>\$6</u>	<u>00</u> / \$0
	Individual Out-of-pocket maximum	\$ 7,550 \$ <u>7,850</u>	
	Family Out-of-pocket maximum	\$15,100 <u>\$15,700</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common	Service Type	Member Cost Share	Deductible
Medical Event			Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$40	
provider's office or	Other practitioner office visit	\$40	
clinic visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35 <u>\$40</u>	
Tests	X-rays and Diagnostic Imaging	\$75 <u>\$85</u>	
	Imaging (CT/PET scans, MRIs)	\$300 <u>\$325</u>	
	Tier 1	\$15 \$1 <u>6</u>	Pharmacy
	•	ψ10 <u>ψ10</u>	deductible
Drugs to treat	Tier 2	\$ 55 \$60	Pharmacy deductible
illness or condition	Tier 3	\$ 8 0 <u>\$90</u>	Pharmacy deductible
		20% up to \$250 per script	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)	\$350 <u>\$400</u>	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	×
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	Х
Hospital stay	delivery, mental health, and substance use)		^
	Physician/surgeon fee	20%	
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	
Holp	Outpatient Rehabilitation and Habilitation services	\$40	
Help recovering or	Skilled nursing care	20%	Х
other special health needs			X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
Cui C	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Dawtel	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

9.5 EHB

	5, 2018March 14, 2019 efits and Coverage	CCSB <u>-only</u>		CCSB-only	
•	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan		Silver Copay Plan	
Actuarial Value - A\	/ Calculator	71.970.5%		71.6 <u>70.2</u> %	
	Plan design includes a deductible?	Yes, Medical/Pharma	ю	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	\$2,000 <u>\$2,250</u> / \$200 <u>\$30</u>	<u>0</u> /\$0	\$ 2,000 \$2,250 / \$ 200 \$3	<u>00</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 4,000 \$4,500 / \$4 00 \$60	<u>0</u> /\$0	\$4,000 <u>\$4,500</u> / \$400 <u>\$6</u>	<u>00</u> / \$0
	Individual Out-of-pocket maximum	\$ 7,55 0 <u>\$7,850</u>		\$ 7,550 \$ <u>7,850</u>	
	Family Out-of-pocket maximum	\$15,100 <u>\$15,700</u>		\$15,100 <u>\$15,700</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	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
Health care provider's	Other practitioner office visit	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
office or clinic visit	Specialist visit	\$80 <u>\$85</u>		\$ 80 \$85	
omno viole				_	
	Preventive care/ screening/ immunization	No charge \$40		No charge \$40	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$75\$85		\$75 <u>\$85</u>	
10313	Imaging (CT/PET scans, MRIs)	20%		\$300	
			Pharmacy		Pharmacy
	Tier 1	\$15 <u>\$17</u>	deductible	\$15 <u>\$17</u>	deductible
Drugs to treat	Tier 2	\$ 55 <u>\$65</u>	Pharmacy deductible	\$5 5 <u>\$65</u>	Pharmacy deductible
illness or condition	Tier 3	#05#00	Pharmacy	#05#00	Pharmacy
condition	Hel 3	\$85 <u>\$90</u>	deductible	\$85 <u>\$90</u>	deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20%		20%	
Outpatient	Physician/surgeon fees	20%		20%	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350\$400	<u>×</u>	\$350\$400	<u>x</u>
Need	Emergency room physician fee (waived if admitted)	No charge	<u> </u>	No charge	<u>~</u>
immediate			V	Ŭ I	V
attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	Х
	Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
Hospital stay	delivery, mental health, and substance use)	20%	Χ	20%	Х
	Physician/surgeon fee	20%	X	20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
behavioral health, or	visits	φ43 <u>φ30</u>		Ф43<u>030</u>	
substance	Mental/behavioral health and substance use disorder other outpatient	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
abuse needs	items and services	φ το<u>ψου</u>		ф 10<u>40</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
recovering or other special	Skilled nursing care	20%	X	20%	Х
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	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	Sealants per Tooth	Not Covered		Not Covered	
Preventive					
	Topical Fluoride Application				
Children	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				

	5, 2018March 14, 2019	0000	
-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB <u>-o</u> Silver	
	·	HDHP P	
Actuarial Value - AV		70.5 71.3	
	Plan design includes a deductible? Integrated Individual deductible	Yes, integr	
	Integrated Family deductible	\$2,500 integ \$5,000 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	,,,,,,,,
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$ 6,650 \$6	<u>850</u>
	Family Out-of-pocket maximum	\$13,300 <u>\$1</u> :	<u>3,700</u>
	HSA plan: Self-only coverage deductible	\$2,500)
_	HSA family plan: Individual deductible	See endr	ote
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	Other practitioner office visit	20%	X
office or	Other production of the visit	2076	Λ
clinic visit	Specialist visit	20%	X
	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 script	X
Drugo to troot	Tier 2	20% up to \$250 per	X
Drugs to treat illness or	1012	script	Λ
condition	Tier 3	20% up to \$250 per script	Х
	Tier 4	20% up to \$250 per	X
	Surgery facility fee (e.g., ASC)	script	X
Outpatient			
services	Physician/surgeon fees	20%	X
	Outpatient visit	20%	Х
	Emergency room facility fee (waived if admitted)	20%	X
Need immediate	Emergency room physician fee (waived if admitted)	0%	X
attention	Medical transportation (including emergency and non-emergency)	20%	X
	Urgent care	20%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
поѕрітаї зтау	Physician/surgeon fee	20%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office		
behavioral	visits	20%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient		,
abuse needs	items and services	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	Х
Help	Outpatient Rehabilitation and Habilitation services	20%	Х
recovering or	Skilled nursing care	20%	X
other special health needs	Durable medical equipment	20%	X
		20%	X
	Hospice service		٨
Child eye care	1 pair of glasses per year (or contact langue in liqu of glasses)	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	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
Ser vices	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	
Oranouomites			

Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
ctuarial Value - AV	/ Calculator	94.2 <u>94.5</u>		87.9 <u>87.7</u> %	
	Plan design includes a deductible?	Yes, Medical/F		Yes, Medical/Pharma	асу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 <u>\$1,400</u> / \$50 <u>\$100</u>	0 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/\$0	\$1,300 <u>\$2,800</u> / \$100 <u>\$2</u>	<u>00</u> / \$0
	Individual Out-of-pocket maximum	\$1,000)	\$ 2,600 \$2,700	
	Family Out-of-pocket maximum	\$2,000)	\$5,200 <u>\$5,400</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	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$15 <u>\$20</u>	
Tests	X-rays and Diagnostic Imaging	\$8		\$30 <u>\$40</u>	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1			\$5	
		\$3			Pharma
Drugs to treat illness or	Tier 2	\$10		\$ 20 <u>\$25</u>	deductik Pharma
condition	Tier 3	\$15		\$35 \$45	deductik
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharma deductib
	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		\$100 <u>\$150</u>	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$30	×	\$75	×
attention	Urgent care		^		Α
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$5		\$15	
Hospital stay	delivery, mental health, and substance use)	10%	Х	15%	Х
	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	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	15%	X
other special health needs	Durable medical equipment	10%		15%	^
	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	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 Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
	,				
Services	Prosthodontics				
Services	Prosthodontics Oral Surgery				

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
uarial Value - AV	/ Calculator	73.9 73.8	-
	Plan design includes a deductible?	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	,
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 \$3,700 / \$175 <u>\$2</u>	75 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,400 <u>\$7,400</u> / \$350 <u>\$5</u>	<u>50</u> / \$0
	Individual Out-of-pocket maximum	\$ 6,300 \$6,550	
	Family Out-of-pocket maximum	\$12,600 <u>\$13,100</u>	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductil Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's office or	Other practitioner office visit	\$35	
clinic visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35\$4 <u>0</u>	
Tests	X-rays and Diagnostic Imaging	 \$75 \$85	
	Imaging (CT/PET scans, MRIs)	\$300\$32 <u>5</u>	
			Pharma
	Tier 1	\$15 <u>\$16</u>	deductil
Drugs to treat	Tier 2	\$50 <u>\$55</u>	deductil
condition	Tier 3	\$75 <u>\$85</u>	Pharma deductil
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductil
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350 <u>\$400</u>	
Need	Emergency room physician fee (waived if admitted)	No charge	
leed mmediate ttention	Medical transportation (including emergency and non-emergency)	\$250	×
attention	Urgent care		^
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$35	
Hospital stay	delivery, mental health, and substance use)	20%	Х
	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	
Holp	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or	·		.,
other special health needs	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
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	Sealants per Tooth	Not Covered	
Preventive	·		
	Topical Fluoride Application		
01.11.12	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Ohild Daniel	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

mber Cost Share :	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	
uarial Value - A\	√ Calculator	60.9 <u>61.3</u> %		61.6 <u>62.0</u> 9	%
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integra	ated
	Integrated Individual deductible	N/A		\$6,000 <u>\$6,950</u> in	tegrate
	Integrated Family deductible	N/A		\$12,000 <u>\$13,900</u> i	integra
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	60	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 /	\$0	N/A	
	Individual Out-of-pocket maximum	\$ 7,550 <u>\$7,850</u>		\$6,650 <u>\$6,9</u>	<u>950</u>
	Family Out-of-pocket maximum	\$15,100 <u>\$15,70</u>	<u>)</u>	\$13,300 <u>\$13</u>	
	HSA plan: Self-only coverage deductible	N/A		\$6,000 <u>\$6,9</u>	
	HSA family plan: Individual deductible	N/A		\$6,000 <u>\$6,9</u>	
common ledical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Dedu App
	Primary care visit to treat an injury, illness, or condition	\$75 <u>\$65</u>	After 1st three non- preventive visits	40% 0%	×
ealth care rovider's	Other practitioner office visit	\$75 <u>\$65</u>	After 1st three non- preventive visits	40% 0%	>
ffice or linic visit	Specialist visit	\$ 10 5 <u>\$95</u>	After 1st three non-	40% 0%	>
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge	
	Laboratory Tests	\$40		40%0%)
ests	X-rays and Diagnostic Imaging	1 00% 40%	×	4 0% 0%	>
	Imaging (CT/PET scans, MRIs)	1 00% 40%	X	4 0% 0%)
		100% up to \$500 per script after		40% up to \$500	
	Tier 1	pharmacy deductible \$18	Pharmacy Deductible	per script0%)
rugs to treat	Tier 2	100%40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script0%)
ness or ondition	Tier 3	100%40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script0%	,
	Tier 4	100%40% up to \$500 per script	Pharmacy	40% up to \$500	
		after pharmacy deductible	Deductible	per script0%	
utpatient	Surgery facility fee (e.g., ASC)	100% <u>40%</u>	X	4 0% 0%	>
ervices	Physician/surgeon fees	100% <u>40%</u>	X	40% <u>0%</u>)
	Outpatient visit	100% <u>40%</u>	X	40% 0%)
	Emergency room facility fee (waived if admitted)	100% <u>40%</u>	X	4 0% 0%]
eed nmediate	Emergency room physician fee (waived if admitted)	No charge		0%	
ttention	Medical transportation (including emergency and non-emergency)	100% <u>40%</u>	×	40% 0%	;
	Urgent care	\$75 <u>\$65</u>	After 1st three non- preventive visits	4 0% 0%	:
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100% 40%	X	40% 0%	;
ospital stay	delivery, mental health, and substance use) Physician/surgeon fee	100%40%	X	4 0 % <u>0%</u>	,
lontal backle	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-		
lental health, ehavioral ealth, or	visits	\$75 <u>\$65</u>	preventive visits	4 0 % <u>0%</u>	,
ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$75 <u>\$65</u>	X	40% <u>0%</u>	,
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	100% 40%	X	40% 0%	
olm.	Outpatient Rehabilitation and Habilitation services	\$ 75 \$65		40% 0%	,
elp ecovering or	•				
ther special ealth needs	Skilled nursing care	100% <u>40%</u>	X	40% 0%]
Janus Heeds	Durable medical equipment	100% <u>40%</u>	X	40% 0%] :
	Hospice service	No charge		0%	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
hild Douts!	Preventive - Cleaning				
hild Dental liagnostic	Preventive - X-ray	Not Covered		Not Covered	
nd reventive	Sealants per Tooth	INOL COVERED		NOL COVERED	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
asic ervices	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental		Not Covered		Not Cover-	
Major Services	Periodontics (other than maintenance)	INOT COVERED		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of	Renefits a	and Coverage

Summary of Benefits and Coverage				
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan		
Actuarial Value - AV Calculator				
Plan design includes a deductible?			Yes, integrated	
	Integrated Individual deductible Integrated Family deductible	\$7,900 <u>\$8,200</u> integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$15,800 <u>\$16,400</u> integrated N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
	Individual Out-of-pocket maximum		\$ 7,900 \$8,200	
Family Out-of-pocket maximum				
HSA plan: Self-only coverage deductible HSA family plan: Individual deductible				
0	TO A falling plan. Harridaa deddololo	Manual and Const		
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 office or clinic visit	Other practitioner office visit	0%	After 1st three non- preventive visits	
	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	0%	X	
Tests	X-rays and Diagnostic Imaging	0%	×	
	Imaging (CT/PET scans, MRIs)	0%	×	
	Tier 1	0%	Х	
Drugs to treat	Tier 2	0%	X	
illness or condition	Tier 3	0%	X	
	Tier 4	0%	X	
	Surgery facility fee (e.g., ASC)	0%	X	
Outpatient	Physician/surgeon fees	0%	X	
services	Outpatient visit	0%	X	
	Emergency room facility fee (waived if admitted)	0%	X	
Need	Emergency room physician fee (waived if admitted)	No charge	^	
immediate attention	Medical transportation (including emergency and non-emergency)	0%	X	
attention	Urgent care	0%	After 1st three non-	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	preventive visits	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	X	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	070	After 1st three non-	
behavioral health, or	visits	0%	preventive visits	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient	0%	X	
	items and services			
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	0%	X	
Help recovering or	Outpatient Rehabilitation and Habilitation services	0%	X	
other special health needs	Skilled nursing care	0%	X	
health needs	Durable medical equipment	0%	X	
	Hospice service	0%	X	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	X	
	oral Exam	0%	X	
	Preventive - Cleaning			
Child Dental	Preventive - X-ray			
Diagnostic and	Sealants per Tooth	Not Covered		
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
Child Dental	Endodontics			
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics	Not Covered		

Endnotes to Covered California <u>2019</u>-<u>2020</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 2019-2020 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 \$200-250 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 2019-2020 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.	
2	1) Non-preferred generic drugs;	
	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	Non-preferred brand name drugs or;	
	2) 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.