Date: March 15, 2018 February 14, 2019



Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinum Coinsurance Plan		Platinum Copay Plan	
Actuarial Value - A	AV Calculator	91.7%	Pian	88.989.19	
	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>\$4,500</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		<u>00</u>	\$6,700 <u>\$9,0</u> N/A	<u>00</u>
	HSA family plan: Individual deductible			N/A	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	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	Considired visit	\$30		\$30	
VISIL	Specialist visit				
	Preventive care/ screening/ immunization	No charge		No charge \$15	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$15 \$30		\$30	
10313	A-rays and Diagnostic imaging Imaging (CT/PET scans, MRIs)	10%		\$30 \$75	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15		\$15	
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
		script		script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
services	Physician/surgeon fees	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	
Hospital stay	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	
	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 items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
regulation	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
Help recovering or	·			\$150 per day up to	
other special health needs	Skilled nursing care	10%		5 days	
	Durable medical equipment	10%		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 and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth Topical Fluorida Application				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed Restorative Procedures			See 2019 2020	
Basic	Periodontal Maintenance Services	20%		Dental Copay Schedule	
Services	Periodontal Maintenance Services Crowns and Casts			Scriedulė	
	Endodontics				
Child Dental Major		50%		See 2019 2020 Dental Copay	
Services	Periodontics (other than maintenance) Prosthodontics	JU /0		Schedule Schedule	
Child	Oral Surgery Medically appropriate dentities	500/		Ø4.000	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

-	enefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance	•	Individual-only Copay Pla	_
Actuarial Value - A	AV Calculator	81.8 <u>81.9</u> %		78.1 <u>78.3</u> 9	
	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	\$7,200 <u>\$7,85</u>	<u>50</u>	\$7,200 <u>\$7,8</u>	<u>50</u>
	Family Out-of-pocket maximum	\$14,400 <u>\$15.7</u>	<u>700</u>	\$14,400 <u>\$15.</u>	<u>700</u>
	HSA plan: Self-only coverage deductible	N/A N/A		N/A N/A	
	HSA family plan: Individual deductible	N/A		IN/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
HM	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's office or clinic	Other practitioner office visit	\$30		\$30	
visit	Specialist visit	\$55 <u>\$60</u>		\$ 55 \$60	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35 <u>\$40</u>		\$35 \$40	
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	
Drugs to treat	Tier 2	\$55		\$55	
illness or condition	Tier 3	\$75 <u>\$80</u>		\$75 <u>\$80</u>	
	Tier 4	20% up to \$250 per		20% up to \$250 per	
	Surgery facility fee (e.g., ASC)	script		script	
Outpatient				\$300	
services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$325 <u>\$350</u>		\$325 <u>\$350</u>	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$30		\$30	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20%		\$600 per day up to 5 days No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office				
behavioral health, or substance	visits Mental/behavioral health and substance use disorder other outpatient	\$30		\$30	
abuse needs	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 recovering or	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
other special	Skilled nursing care	20%		\$300 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
Ciliiu 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	NI= =1 · · ·		NI= =/ · · ·	
and Preventive	Sealants per Tooth	No charge		No charge	
, icaciuiae	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 20192020	
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 20192020 Dental Copay	
Services	Prosthodontics	0070		Schedule	
Child	Oral Surgery			A	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Summary of Benefits and Coverage	CCSB-only	CCSB-only
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.1%	79.7%
Plan design includes	a deductible? Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individua	al deductible N/A	<u>N/A</u>
Integrated Family	y deductible N/A	<u>N/A</u>
Individual deductible, NOT integrated: Medical / Pharma	acy / Dental \$250 / \$0 / \$0	<u>\$250 / \$0 / \$0</u>
Family deductible, NOT integrated: Medical / Pharma	acy / Dental \$500 / \$0 / \$0	<u>\$500 / \$0 / \$0</u>
Individual Out-of-pock	ket maximum \$7.850	<u>\$7,850</u>
Family Out-of-pock	ket maximum \$15,700	<u>\$15,700</u>
HSA plan: Self-only coverage	ge deductible N/A	<u>N/A</u>
HSA family plan: Individu	ual deductible N/A	N/A
Common Service Type		ductible Member Cost Share Deductible Applies

	HSA family plan: Individual deductible	uctible <u>N/A</u> <u>N/A</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	<u>\$25</u>		<u>\$25</u>	
Health care provider's	Other practitioner office visit	<u>\$25</u>		\$2 <u>5</u>	
office or clinic	Specialist visit	<u>\$50</u>		<u></u> \$50	
VISIL	Preventive care/ screening/ immunization			_	
	Laboratory Tests	No charge \$25		No charge \$25	
Tests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%		\$27 <u>5</u>	
	Tier 1	<u>\$15</u>		<u>\$15</u>	
Drugs to treat	Tier 2	\$ <u>50</u>		<u>\$50</u>	
illness or					
condition	Tier 3	<u>\$80</u>		<u>\$80</u>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		<u>\$300</u>	
Outpatient services	Physician/surgeon fees	<u>20%</u>		<u>\$40</u>	
	Outpatient visit	<u>20%</u>		<u>20%</u>	
	Emergency room facility fee (waived if admitted)	<u>\$250</u>	<u>X</u>	<u>\$250</u>	<u>X</u>
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	<u>\$250</u>	<u>X</u>	<u>\$250</u>	X
	Urgent care	<u>\$25</u>		<u>\$25</u>	
Haanital atau	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	<u>20%</u>	<u>X</u>	\$600 per day up to 5 days	<u>X</u>
Hospital stay	Physician/surgeon fee	<u>20%</u>	<u>X</u>	No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	<u>\$25</u>		<u>\$25</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	<u>\$25</u>		<u>\$25</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	<u>\$30</u>		<u>\$30</u>	
Help	Outpatient Rehabilitation and Habilitation services	<u>\$25</u>		<u>\$25</u>	
recovering or other special	Skilled nursing care	<u>20%</u>	<u>X</u>	\$300 per day up to 5 days	X
health needs	Durable medical equipment	<u>20%</u>		<u>20%</u>	
	Hospice service	No charge		No charge	
01.71.1	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				
01.11.15	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	<u>No charge</u>		<u>No charge</u>	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	<u>20%</u>		See 2020 Dental Copay	
Services	Periodontal Maintenance Services			<u>Schedule</u>	
	Crowns and Casts				
Child Dental	Endodontics			Son 2020 Dental Const	
Major Services	Periodontics (other than maintenance)	<u>50%</u>		See 2020 Dental Copay Schedule	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	<u>50%</u>		<u>\$1,000</u>	

Summary	of	Renefits	and	Coverage
Sullilliaiv	UI.	Dellellis	anu	Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.		
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	Service Type	Member Cost Share Deductible

	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit	\$40	
office or clinic	Specialist visit	\$80	
VISIC	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35 <u>\$40</u>	
Tests	X-rays and Diagnostic Imaging	\$75 <u>\$85</u>	
lests	Imaging (CT/PET scans, MRIs)	\$300 <u>\$325</u>	
	Tier 1	\$15 <u>\$16</u>	Pharmad deductib
	Tier 2	\$55 \$60	Pharma
Drugs to treat illness or condition	Her Z	\$5 5 <u>\$60</u>	deductib
	Tier 3	\$80 <u>\$90</u>	Pharma deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20%	COGGOID
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350 \$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	Х
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	
		20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	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	
01.11.1	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 Daniel	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	140 charge	
	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		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB <u>-only</u> Silver		CCSB <u>-only</u> Silver	
Actuarial Value - A	·	Coinsurance Plan	1	Copay Plan	
Actuariai value - A	Plan design includes a deductible?	71.970.5% Yes, Medical/Pharma	acv.	71.670.2% Yes, Medical/Pharm	201
	Integrated Individual deductible	N/A	ж	N/A	acy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 2,000 \$2,250 / \$ 200 \$30	<u>00</u> / \$0	\$ 2,000 \$2,250 / \$ 200 \$3	<u>00</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 <u>\$4,500</u> / \$400 <u>\$60</u>	<u>00</u> / \$0	\$4,000 <u>\$4,500</u> / \$400 <u>\$6</u>	<u>00</u> / \$0
	Individual Out-of-pocket maximum	\$7,550 <u>\$7,850</u>		\$7,55 0 <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		N/A N/A	
	HSA family plan: Individual deductible	N/A		IV/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health ages	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 <u>\$85</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75\$85		\$75 <u>\$85</u>	
	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	\$85 <u>\$90</u>	Pharmacy	\$85 <u>\$90</u>	Pharmacy
		20% up to \$250 per script after	deductible Pharmacy	20% up to \$250 per script	deductible Pharmacy
	Tier 4	pharmacy deductible	deductible	after pharmacy deductible	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)	\$350 <u>\$400</u>	<u>X</u>	\$350 <u>\$400</u>	<u>X</u>
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	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X	20%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X	20%	
		2070	X	2070	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$45\$5 0		0.4505 0	
abuse needs	items and services	\$45 <u>\$50</u>		\$45 <u>\$50</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%	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
01.11.7	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 Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 20192020 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		See 2019/2020 Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 20192020 Dental Copay	
Services	Prosthodontics	0070		Schedule	
	Oral Surgery				
Child		500/		#4.000	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Date: March	15, 2018 <u>February 14, 2019</u>		
-	nefits and Coverage	CCSB <u>-o</u>	
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	HDHP PI	
Actuarial Value - A		70.5 <u>71.3</u>	
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible Integrated Family deductible	\$2,500 integ \$5,000 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 line(grateu
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$6,65 0 <u>\$6</u> ,	<u>850</u>
	Family Out-of-pocket maximum	\$ 13,300 \$13	<u>3,700</u>
	HSA plan: Self-only coverage deductible	\$2,500)
	HSA family plan: Individual deductible	See endn	note
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 clinic visit	Specialist visit	20%	X
VISIT	Specialist visit		^
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	20%	X
rests		20%	X
	Imaging (CT/PET scans, MRIs)	20% 20% up to \$250 per	X
	Tier 1	script	X
Drugs to treat	Tier 2	20% up to \$250 per script	X
illness or condition	Tier 3	20% up to \$250 per	X
	Tiel 3	script	X
	Tier 4	20% up to \$250 per script	X
	Surgery facility fee (e.g., ASC)	20%	Х
Outpatient services	Physician/surgeon fees	20%	Х
	Outpatient visit	20%	Х
	Emergency room facility fee (waived if admitted)	20%	Х
Need immediate attention	Emergency room physician fee (waived if admitted)	0%	Х
	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%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X
Mantal haalth	Mental/behavioral health and substance use disorder outpatient office		
Mental health, 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%	X
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 Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	20-1	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
Object	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	
Orthodontics			

Summary of Be	nefits and Coverage	Cil D	la	Cilven Blan	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
Actuarial Value - A		94.2 94.		87.9<u>87.7</u>%	
	Plan design includes a deductible?		Pharmacy	Yes, Medical/Pharm	acy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 <u>\$1,400</u> / \$50 <u>\$10</u>	0 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$ 1,300 \$2,800 / \$ 100 \$2	
	Individual Out-of-pocket maximum	\$1,00	0	\$2,600 <u>\$2,700</u>	
	Family Out-of-pocket maximum	\$2,00	0	\$ 5,200 \$ <u>5,400</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
Haaldh aana	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				
		\$3		\$5	Pharmacy
Drugs to treat illness or	Tier 2	\$10		\$ 20 \$2 <u>5</u>	deductible
condition	Tier 3	\$15		\$35 \$45	Pharmacy deductible
	Tier 4	10% up to \$150 per script		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		\$100 <u>\$150</u>	
Need immediate attention	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$30	X	\$75	Х
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	X	15%	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		15%	
		1070		1070	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	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 other special	Skilled nursing care	10%	X	15%	X
health needs	Durable medical equipment	10%		15%	
	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				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Ne share		N	
and Preventive	Sealants per Tooth	No charge		No charge	
Svonuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics Desired action (when the province access)	F00'		F637	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		50%	

•	nefits and Coverage	Silver Plan	
	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	-
Actuarial Value - A		73.973.8%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm	acy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 2,200 \$3,700 / \$175 <u>\$2</u>	<u>75</u> / \$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 HSA family plan: Individual deductible	N/A N/A	
Common			Deductible
Medical Event	Service Type	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$35	
provider's office or clinic	Other practitioner office visit	\$35	
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 <u>\$16</u>	Pharmacy deductible
Drugs to treat	Tier 2	\$ 50 \$55	Pharmacy
illness or condition	Tier 3	\$75 \$85	deductible Pharmacy
	Tier 4	20% up to \$250 per script	deductible Pharmacy
	Surgery facility fee (e.g., ASC)	after pharmacy deductible 20%	deductible
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350\$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate			Y
attention	Medical transportation (including emergency and non-emergency)	\$250	X
	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	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	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%	X
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Ohit	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 Diagnostic	Preventive - X-ray	N	
and Preventive	Sealants per Tooth	No charge	
	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		
A1 17 1	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	
Actuarial Value - A	AV Calculator	60.9 <u>61.3</u> %		61.6 62.0	
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integra	ated
	Integrated Individual deductible	N/A		\$6,000 <u>\$6,950</u> in	ntegrated
	Integrated Family deductible	N/A		\$12,000 <u>\$13,900</u>	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>		
	Family Out-of-pocket maximum		0	\$13,300 <u>\$13</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			\$6,000 <u>\$6,9</u> \$6,000 <u>\$6,9</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	\$75 \$65	After 1st three non-	40% 0%	Х
Health care		_	preventive visits After 1st three non-	_	
provider's office or clinic	Other practitioner office visit	\$75 <u>\$65</u>	preventive visits	40% 0%	X
visit	Specialist visit	\$105 <u>\$95</u>	After 1st three non- preventive visits	4 0% 0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		40% 0%	X
Tests	X-rays and Diagnostic Imaging	100% <u>40%</u>	X	40% 0%	X
	Imaging (CT/PET scans, MRIs)	100% 40%	X	4 0% 0%	Х
	Tier 1	100% up to \$500 per script after	Pharmacy	40% up to \$500	X
		pharmacy deductible \$18	Deductible	per script <u>0%</u> 40% up to \$500	
Drugs to treat	Tier 2	100%40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	per script0%	Х
condition	Tier 3	100%40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script0%	Х
	Tion 4	100%40% up to \$500 per script	Pharmacy	40% up to \$500	
	Tier 4	after pharmacy deductible	Deductible	per script0%	Х
Outpatient	Surgery facility fee (e.g., ASC)	100% <u>40%</u>	X	40% 0%	Х
services	Physician/surgeon fees	100% 40%	X	40% 0%	X
	Outpatient visit	100% 40%	X	40% 0%	Х
	Emergency room facility fee (waived if admitted)	100% 40%	X	40% 0%	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge		0%	X
	Medical transportation (including emergency and non-emergency)	100% <u>40%</u>	X	4 0% 0%	Х
	Urgent care	\$75 <u>\$65</u>	After 1st three non- preventive visits	40% 0%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100% 40%	X	40% 0%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	 100% 40%	X	40% 0%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-		
behavioral	visits	\$75 <u>\$65</u>	preventive visits	40% 0%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$75 <u>\$65</u>	X	4 0% 0%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	100% <u>40%</u>	X	40% 0%	Х
Help	Outpatient Rehabilitation and Habilitation services	\$75 <u>\$65</u>		4 0% 0%	X
recovering or other special	Skilled nursing care	100% 40%	X	40% 0%	Х
health needs	Durable medical equipment	100% 40%	X	40% 0%	Х
	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				
	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%	
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%	

20192020 Patient-Centered Benefit Plan Designs

Oral Surgery

Medically necessary orthodontics

0%

Χ

20192020 Pat 10.0 EHB	tient-Centered Benefit Plan Designs		
Date: March	15, 2018<u>February</u> 14, 2019		
-	enefits and Coverage	0.1	and to Bloom
	e amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan
Actuarial Value - A	Plan design includes a deductible?	Vas	integrated
	Integrated Individual deductible	\$7,900\\$8,200 integrated	
	Integrated Family deductible	\$15,800 <u>\$16,400</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		900 <u>\$8,200</u>
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		8 00 <u>\$16,400</u> 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 non- preventive visits
Health care	Other practitioner office visit	0%	After 1st three non-
provider's office or clinic	,		preventive visits
visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	.,
Tests	Laboratory Tests V-rays and Diagnostic Imaging	0%	X
rests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
Drugs to treat	Tier 2	0%	X
illness or condition	Tier 3	0%	×
	Tim 4	00/	
	Tier 4	0%	X
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
Nood	Emergency room facility fee (waived if admitted)	0%	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	0%	X After 1st three non-
	Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	preventive visits
Hospital stay	delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
health, or			proveniire rione
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%	×
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or	Skilled nursing care	0%	×
other special health needs	Durable medical equipment	0%	X
	Hospice service	0%	×
	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 Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	X
Services	Periodontal Maintenance Services	070	^
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	0%	X
	Prosthodontics		



Summary of be	nefits and Coverage	▼ 1M			
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance Plan		Platinum	
	·			Copay Plan 88.989.1%	
Actuarial Value - A		91.7%			O
	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 / \$	
	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>\$4.5</u>	<u>00</u>
	Family Out-of-pocket maximum	\$6,700 <u>\$9,0</u>	<u>00</u>	\$6,700 <u>\$9,0</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
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
provider's	Other practitioner office visit	\$15		\$15	
office or 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	
Drugs to treat	Tier 2	\$15		\$15	
illness or condition	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	
3CI VICC3	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	10%		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)	400/		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	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services	φισ		φιο	
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	Skilled nursing 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 ove core	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					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
OLIV D	Endodontics				
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
, 30. 71003	Prosthodontics				
	Oral Surgery				
Child		N. C		N. C	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		<u>Individual-only</u> Gold		Individual-only Gold	
	·	Coinsurance Plan		Copay Pla	
Actuarial Value - A		81.8 81.9%	0	78.1 <u>78.3</u> 9	o .
	Plan design includes a deductible? Integrated Individual 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 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,200 <u>\$7,8</u> 5		\$7,200 \$7,8	
	Family Out-of-pocket maximum	\$14,400 <u>\$15,</u> 7	<u>700</u>	\$14,400 <u>\$15,</u>	700
	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
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	\$55 <u>\$60</u>		\$5 5 <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 \$75		\$55 <u>\$75</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat illness or	Tier 2	\$55		\$55	
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	
	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	
	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	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	
	Home health care (cost share per visit)	20%		\$30	
		\$30			
Help recovering or	Outpatient Rehabilitation and Habilitation services	·		\$30 \$300 per day up to	
other special health needs	Skilled nursing care	20%		5 days	
nounn neeus	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				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray	Not O		N-+ O	
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 Prosthodontics	1401 GOVEREU		140t Govereu	
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

	rs, 2018 rebruary 14, 2019 nefits and Coverage	CCSB-only		CCSB-only		
•	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance I	<u>Plan</u>	Gold Copay Plan		
Actuarial Value - A	.V Calculator	78.1%		79.7%		
	Plan design includes a deductible?	Yes, Medical/Pharm	<u>acy</u>	Yes, Medical/Phari	<u>macy</u>	
	Integrated Individual deductible	<u>N/A</u>		<u>N/A</u>		
	Integrated Family deductible	<u>N/A</u>		<u>N/A</u>		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$250 / \$0 / \$0		\$250 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum	\$500 / \$0 / \$0 \$7,850		\$500 / \$0 / \$0 \$7,850		
	Family Out-of-pocket maximum	\$15,700		\$15,70 <u>0</u>		
	HSA plan: Self-only coverage deductible			<u>N/A</u>		
	HSA family plan: Individual deductible	<u>N/A</u>		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	<u>Deductible</u> <u>Applies</u>	
	Primary care visit to treat an injury, illness, or condition	<u>\$25</u>		<u>\$25</u>		
Health care provider's	Other practitioner office visit	<u>\$25</u>		\$2 <u>5</u>		
office or clinic visit	Specialist visit	\$50		\$50		
VIOL	Preventive care/ screening/ immunization	\$50 No charge		No charge		
	Laboratory Tests	\$25		\$25		
Tests	X-rays and Diagnostic Imaging	<u>\$65</u>		<u>\$65</u>		
	Imaging (CT/PET scans, MRIs)	<u>20%</u>		<u>\$275</u>		
	Tier 1	<u>\$15</u>		<u>\$15</u>		
	Tier 2	\$ 50		050		
Drugs to treat illness or	Tiel 2	<u>\$50</u>		<u>\$50</u>		
condition	Tier 3	<u>\$80</u>		<u>\$80</u>		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	<u>20%</u>		<u>\$300</u>		
Outpatient services	Physician/surgeon fees	<u>20%</u>		<u>\$40</u>		
00111000	Outpatient visit	<u>20%</u>		<u>20%</u>		
	Emergency room facility fee (waived if admitted)	<u>\$250</u>	<u>x</u>	<u>\$250</u>	<u>X</u>	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge		
attention	Medical transportation (including emergency and non-emergency)	<u>\$250</u>	<u>X</u>	<u>\$250</u>	<u>X</u>	
	Urgent care	<u>\$25</u>		<u>\$25</u>		
Heavital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	<u>20%</u>	<u>X</u>	\$600 per day up to 5 days	<u>X</u>	
Hospital stay	Physician/surgeon fee	<u>20%</u>	<u>x</u>	No charge		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$2 <u>5</u>		\$2 <u>5</u>		
behavioral health, or	visits	<u>\$23</u>		<u> </u>		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient	<u>\$25</u>		\$2 <u>5</u>		
	items and services					
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	<u>\$30</u>		<u>\$30</u>		
Help recovering or	Outpatient Rehabilitation and Habilitation services	<u>\$25</u>		<u>\$25</u>		
other special health needs	Skilled nursing care	<u>20%</u>	X	\$300 per day up to 5 days	X	
noam necus	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) Oral Exam	No charge		No charge		
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic and Preventive		Not Covered		Not Covered		
and Preventive	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 Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		
Orthodomics						

	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
Actuarial Value - A	.V Calculator	71.8 71.7%	
	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 <u>\$4,000</u> / \$ 200 <u>\$3</u>	<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	
	THO VIGINITY Plant. Individual deduction	1471	
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	Other practitioner office visit	\$40	
office or 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 \$32 <u>5</u>	
	Tier 1	\$15 \$16	Pharmacy
			deductible Pharmacy
Drugs to treat illness or	Tier 2	\$55 <u>\$60</u>	deductible
condition	Tier 3	\$80 <u>\$90</u>	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy
	Tiel 4	after pharmacy deductible	deductible
Outnotions	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	Х
	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/behavioral health and substance use disorder outpatient office		
Mental health, behavioral health, or	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	
regulation	Home health care (cost share per visit)	\$45	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$40	
other special health needs	Skilled nursing care	20%	X
nealth needs	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		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	1431 OUVEIGU	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered	
major dervices	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	
Orthodontics		AND CONCIEC	

Summary of Benefits and Coverage		CCSB <u>-only</u> Silver		CCSB <u>-only</u> Silver	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan		Copay Plan	
Actuarial Value - A		71.970.5%		71.6 70.2%	
	Plan design includes a deductible?	Yes, Medical/Pharma	acy	Yes, Medical/Pharmacy N/A	
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 2,000 \$2,250 / \$ 200 \$30	00 / \$0	\$ 2,000 \$2,250 / \$ 200 \$3	00 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 <u>\$4,500</u> / \$400 <u>\$60</u>		\$4,000 <u>\$4,500</u> / \$400 <u>\$6</u>	
	Individual Out-of-pocket maximum	\$7,550 <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	e 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 \$85		\$ 80 \$8 <u>5</u>	
11011	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75 <u>\$85</u>		\$75 <u>\$85</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	\$15\$17	Pharmacy	\$15\$17	Pharmacy
	Hell	ф 13 <u>ф 17</u>	deductible	φ13 <u>φ17</u>	deductible
Drugs to treat	Tier 2	\$55 \$65	Pharmacy deductible	\$55 \$65	Pharmacy deductible
illness or condition	Tier 3	\$85 <u>\$90</u>	Pharmacy	\$85 <u>\$90</u>	Pharmacy
		20% up to \$250 per script after	deductible Pharmacy	20% up to \$250 per script	deductible Pharmacy
	Tier 4	pharmacy deductible	deductible	after pharmacy deductible	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)	\$350 <u>\$400</u>	<u>X</u>	\$350 \$400	<u>X</u>
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	Х
	Urgent care	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	20%	Х
Hospital stay	Physician/surgeon fee	20%	X	20%	
Mandallanki	Mental/behavioral health and substance use disorder outpatient office				
Mental health, behavioral	visits	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$45 <u>\$50</u>		\$45 <u>\$50</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	Skilled nursing care	20%	X	20%	X
other special health needs	Durable medical equipment	20%		20%	
	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	. to ondigo		. to onargo	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic	Sealants per Tooth	Not Covered		Not Covered	
and Preventive	·				
	Topical Fluoride Application Space Maintainers - Fixed				
	Space Maintainers - Fixed Rectorative Procedures				
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics Desired action (when the provint access)	N		N	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

20192020 Patient-Centered Benefit Plan Designs

	1 5, 2018 February 14, 2019	0000	
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB <u>-o</u> Silver	
		HDHP P	
Actuarial Value - A	Plan design includes a deductible?	70.5 <u>71.3</u> Yes, integr	
	Integrated Individual deductible	\$2,500 integrated	
	Integrated Family deductible	\$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 <u>\$6.</u>	<u>850</u>
	Family Out-of-pocket maximum	\$13,300 <u>\$13</u>	<u>3,700</u>
	HSA plan: Self-only coverage deductible	\$2,500	
1	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%	Х
office or clinic visit	Specialist visit	20%	Х
			X
	Preventive care/ screening/ immunization Laboratory Tests	No charge 20%	Х
Tests	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
		20% up to \$250 per	
	Tier 1	script	Х
Drugs to treat	Tier 2	20% up to \$250 per script	Х
illness or condition	Tier 3	20% up to \$250 per	Х
		script	^
	Tier 4	20% up to \$250 per script	Х
	Surgery facility fee (e.g., ASC)	20%	Х
Outpatient services	Physician/surgeon fees	20%	Х
33.11333	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	Х
Need	Emergency room physician fee (waived if admitted)	0%	Х
immediate attention	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	20%	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X
		2076	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	Х
health, or substance	Manage (final providers) by a laboratory of the second section of the section		
abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	Х
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 other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	Х
	Hospice service	0%	Х
Obit	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	,,	00.0100	

Summary	of /	Benefits	and	Coverage
---------	------	-----------------	-----	----------

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 100%-150% FPL		Silver Plan		
Actuarial Value - A	V Calculator	94.294.5%		150%-200% FPL 87.987.7%		
	Plan design includes a deductible?	Yes, Medical/Pharmacy		Yes, Medical/Pharmacy		
	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>\$10</u>	<u>0</u> /\$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	0	\$ 2,600 \$2,700		
	Family Out-of-pocket maximum	\$2,000	0	\$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 Deductible Share Applies		Member Cost Share	Deductible Applies	
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
provider's office or clinic	Other practitioner office visit	\$5		\$15		
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 \$40		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
	Tier 1					
	IIGI I	\$3		\$5		
Drugs to treat	Tier 2	\$10		\$20 <u>\$25</u>	Pharmacy deductible	
illness or condition	Tier 3	\$15		\$35 \$4 <u>5</u>	Pharmacy	
Condition	Tid 3				deductible	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
	Surgery facility fee (e.g., ASC)	10%		15%		
Outpatient	Physician/surgeon fees	10%		15%		
services	Outpatient visit	10%		15%		
	Emergency room facility fee (waived if admitted)	\$50		\$100\$150		
Need	Emergency room physician fee (waived if admitted)	No charge		No charge		
immediate			V	G	V	
attention	Medical transportation (including emergency and non-emergency)	\$30	Х	\$75	Х	
	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%	Χ	15%	Χ	
opna.o.ay	Physician/surgeon fee	10%		15%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	0.5		045		
behavioral	visits	\$5		\$15		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0-		0. -		
abuse needs	items and services	\$5		\$15		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	\$3		\$15		
Holo	Outpatient Rehabilitation and Habilitation services	\$5		\$15		
Help recovering or			V		V	
other special health needs	Skilled nursing care	10%	Х	15%	Х	
	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					
	Preventive - Cleaning					
Child Dental	Preventive - X-ray	N-4 G		No. Co.		
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered		
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Day	Restorative Procedures					
Child Dental Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
	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		

Date: March 15, 2018 February 14, 2019

-	nefits and Coverage	Silver Plan	
	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	
Actuarial Value - A		73.973.8%	1001
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm	lacy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 \$3,700 / \$175 <u>\$2</u>	<u>75</u> / \$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 <u>\$6.550</u>	
	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	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$35	
provider's office or clinic	Other practitioner office visit	\$35	
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 <u>\$16</u>	Pharmacy deductible
Drugs to treat	Tier 2	\$50 \$55	Pharmacy
illness or condition	Tier 3	_	deductible Pharmacy
condition	Her 3	\$75 <u>\$85</u>	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%	
33.7.000	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$35 0 <u>\$400</u>	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	Х
	Urgent care	\$35	
	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%	
		2070	
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 other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	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		NOT COVERED	

-	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze	
Actuarial Value - A	V Calculator	60.9 61.3%		HDHP Plan 61.662.0%	
Actualian value 7	Plan design includes a deductible?	Yes, Medical/Pharr	macy	Yes, integrated	
	Integrated Individual deductible	N/A	,	\$6,000 <u>\$6,950</u> in	
	Integrated Family deductible	N/A		\$12,000 <u>\$13,900</u> i	-
	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>		\$ 6,65 0 <u>\$6.9</u>	9 <u>50</u>
	Family Out-of-pocket maximum	\$15,100 <u>\$15,70</u>	<u>0</u>	\$13,300 <u>\$13</u>	<u>,900</u>
	HSA plan: Self-only coverage deductible	N/A		\$ 6,000 <u>\$6,9</u>	<u>950</u>
	HSA family plan: Individual deductible	N/A		\$6,000 <u>\$6,9</u>	<u>950</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	\$75 <u>\$65</u>	After 1st three non- preventive visits	4 0% 0%	X
Health care provider's	Other practitioner office visit	\$75 <u>\$65</u>	After 1st three non- preventive visits	40% 0%	X
office or clinic	Constitution in the	0405005	After 1st three non-	400/00/	
VISIL	Specialist visit	\$ 105 <u>\$95</u>	preventive visits	40% 0%	X
	Preventive care/ screening/ immunization	No charge		No charge	V
	Laboratory Tests	\$40		4 0% 0%	X
Tests	X-rays and Diagnostic Imaging	100% <u>40%</u>	X	4 0% 0%	X
	Imaging (CT/PET scans, MRIs)	100% <u>40%</u>	X	40% <u>0%</u>	X
	Tier 1	100% up to \$500 per script after pharmacy deductible \$18	Pharmacy Deductible	40% up to \$500 per script0%	X
Drugs to treat	Tier 2	100%40% up to \$500 per script	Pharmacy	40% up to \$500	X
illness or		after pharmacy deductible 100%40% up to \$500 per script	Deductible Pharmacy	per script0% 40% up to \$500	
condition	Tier 3	after pharmacy deductible	Deductible	per script0%	X
	Tier 4	100%40% up to \$500 per script	Pharmacy	40% up to \$500	X
	Company facility for (a.g., ACC)	after pharmacy deductible	Deductible	per script0%	V
Outpatient	Surgery facility fee (e.g., ASC)	100% <u>40%</u>	X	40% 0%	X
services	Physician/surgeon fees	100% 40%	X	40% 0%	X
	Outpatient visit	100% 40%	X	40% 0%	X
	Emergency room facility fee (waived if admitted)	100% <u>40%</u>	X	40% 0%	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge		0%	X
attention	Medical transportation (including emergency and non-emergency)	100% 40%	X	40% 0%	X
	Urgent care	\$75 <u>\$65</u>	After 1st three non- preventive visits	40% 0%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100% 40%	X	40% 0%	x
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	100% 40%	×	40% 0%	X
		40070 <u>4070</u>		4070 <u>070</u>	Λ
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$75 <u>\$65</u>	After 1st three non- preventive visits	40% 0%	X
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$75 <u>\$65</u>	X	40% <u>0%</u>	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	100% <u>40%</u>	X	40% 0%	X
Help	Outpatient Rehabilitation and Habilitation services	\$75 <u>\$65</u>		40% 0%	Х
recovering or other special	Skilled nursing care	100% 40%	×	40% 0%	Х
health needs	Durable medical equipment	100%40%	X	40%0%	X
	Hospice service	No charge		9%	X
	Eye exam	-			^
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	Not Co		Not Course !	
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				
Child Dental	Endodontics Desired the three three transports of the transport of the tr	N. G		N. C	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Benefits and Coverage		Cotool	trankia Dlan
	amounts describe the Enrollee's out of pocket costs.	Catasi	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 Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A N/A	
	Individual Out-of-pocket maximum	\$7, 9	900 \$8,200
	Family Out-of-pocket maximum	\$15, 8	300 <u>\$16,400</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	0%	After 1st three non- preventive visits
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	0%	X
Drugs to treat	Tier 2	0%	×
illness or			
condition	Tier 3	0%	X
	Tier 4	0%	x
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient	Physician/surgeon fees	0%	×
services	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%	×
attention	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	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
health, or	Viole		preventive visits
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	x
Brognanov	Prenatal care and preconception visits	No oborgo	
Pregnancy	·	No charge	V
	Home health care (cost share per visit)	0%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	0%	X
other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
	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		
Child Destal	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>2019-2020</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 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.