Covered California 2020 Patient-Centered Benefit Plan Designs¹

Final Board-approved Proposed March 14 May 16, 2019

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



immary of Bei	nefits and Coverage	TA	И		
-	amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance		Platinum Copay Pla	
tuarial Value - A	V Calculator	91.7%		89.1%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$15	Арріїез	\$15	Арріїсо
Health care 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	
Orugs to	Tier 2	\$15		\$15	
reat illness or condition	Tier 3				
n condition		\$25 10% up to \$250 per		\$25 10% up to \$250 per	
	Tier 4	script		script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
Need mmediate	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
ttention	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	
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		5 days No charge	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
pehavioral	visits	ψισ		Ψίδ	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services	φισ		φιο	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
ecovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days	
nealth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eve	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	o o			
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive					
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		See 2020 Dental Copay Schedule	
Services	Periodontal Maintenance Services			, Ly Sonsadio	
	Crowns and Casts				
Child Dental	Endodontics			See 2020 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

ember Cost Sna	re amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
ctuarial Value -	AV Calculator	81.9 81.8%)	78.3%	
	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	\$7,850 <u>\$7.80</u>	<u>)0</u>	\$7,850 <u>\$7.8</u>	<u>00</u>
	Family Out-of-pocket maximum	\$ 15,700 \$15,6	<u>800</u>	\$ 15,700 <u>\$15,</u>	<u>600</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	Deduc Appli
	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's	Other practitioner office visit	\$30		\$30	
office or clinic visit	Specialist visit	\$60 <u>\$65</u>		\$60 <u>\$65</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
30.0					
	Imaging (CT/PET scans, MRIs)	20%		\$275	
Drugs to treat illness or condition	Tier 1	\$15		\$15	
	Tier 2	\$55		\$55	
or condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
mmediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention					
	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		2070		110 onargo	
nealth, oehavioral	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	
lelp	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
ecovering o	Skilled pursing care	20%		\$300 per day up to	
other specia nealth needs				5 days	
	Durable medical equipment	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				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	N		N	
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		20%		See 2020 Dental Copay Schedule	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics			See 2020 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

Summary of Be	nefits and Coverage	CCSB-only		CCSB-only	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Pla	n	Gold Copay Plan	
Actuarial Value - A	V Calculator	78.1%		79.6 79.7%	
	Plan design includes a deductible?	Yes, Medical/Pharma	acy	Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$250 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$500 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,800</u>		\$7,850 <u>\$7,800</u>	
	Family Out-of-pocket maximum	\$ 15,700 \$15,600		\$15,700 <u>\$15,60</u>	<u>0</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common	FIGA family plan. marvioual deduction	19/74		IV/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
LVOIIL	Primary care visit to treat an injury, illness, or condition	\$25		\$25	
Health care					
provider's office or	Other practitioner office visit	\$25		\$25	
clinic visit	Specialist visit	\$50		\$50	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$25	
Tests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
	Tion 2			·	
Drugs to treat illness	Tier 2	\$50		\$50	
or condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient	Physician/surgeon fees	20%			
services				\$40	
	Outpatient visit	20%	V	20%	V
Need immediate	Emergency room facility fee (waived if admitted)	\$250 Nachana	X	\$250 Name to a second	Х
	Emergency room physician fee (waived if admitted)	No charge	.,	No charge	V
attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	Х
	Urgent care	\$25		\$25	
Hospital stay	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	Χ
, , , , , , , , , , , , , , , , , , , ,	Physician/surgeon fee	20%	Х	No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	\$25		\$25	
health, behavioral	visits	ΨΖΟ		Ψ20	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$25		\$25	
abuse needs	items and services	Ψ20		Ψ20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$30		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$25	
recovering or other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х
health needs	Durable medical equipment	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				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			0	
Basic Services	Periodontal Maintenance Services	20%		See 2020 Dental Copay Schedule	
OUI VICES	Crowns and Casts				
	Endodontics				
Child Dental Major		50%		See 2020 Dental Copay	
Services	Periodontics (other than maintenance) Prosthodontics	3U%		Schedule	
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Summary of Benefits and Coverage						
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Individual-only Silver Plan				
Actuarial Value - A	AV Calculator	71.7 <u>71.8</u> %				
	Plan design includes a deductible?	Yes, Medical/Pharmacy				
	Integrated Individual deductible	N/A				
	Integrated Family deductible	N/A				
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$0				
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$0				
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,800</u>				
	Family Out-of-pocket maximum	\$ 15,700 \$15,600				
	HSA plan: Self-only coverage deductible	N/A				
	HSA family plan: Individual deductible	N/A				
Common	Camina Tuna	Deductible				

	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's office or clinic visit	Other practitioner office visit	\$40	
	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmacy deductible
Drugs to	Tier 2	\$60	Pharmac
treat illness or condition	Tier 3	\$90	deductible Pharmac
or condition	Hel 3		deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$40	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
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	
Child eye	Eye exam	No charge	
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	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

	nefits and Coverage	CCSB-only		CCSB-only	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan	,	Silver Copay Plan	
Actuarial Value - A	V Calculator	70.5%		70.2%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$0	
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,800</u>		\$7,850 <u>\$7,800</u>	
	Family Out-of-pocket maximum	· -		\$ 15,700 \$15,600	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common	HOA faithly plant. Individual decidence	IVA		IV/A	
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$50		\$50	
Health care	Timely date visit to treat an injury, inness, or condition	φου		φου	
provider's office or	Other practitioner office visit	\$50		\$50	
clinic visit	Specialist visit	\$85		\$85	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$85		\$85	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	\$17	Pharmacy	\$17	Pharmacy
		φ1/	deductible	φ1/	deductible
Drugs to treat illness	Tier 2	\$65	Pharmacy deductible	\$65	Pharmacy deductible
or condition	Tier 3	\$90	Pharmacy	\$90	Pharmacy
		20% up to \$250 per script after	deductible Pharmacy	20% up to \$250 per script after	deductible Pharmacy
	Tier 4	pharmacy deductible	deductible	pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	20%		20%	
Outpatient services	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$400	X	\$400	Χ
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	Χ
	Urgent care	\$50		\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X	20%	Х
Hospital stay	delivery, mental health, and substance use)	20%	X	20%	
Mental	Physician/surgeon fee	2076	^	2076	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$50	
behavioral health, or					
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$50	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
-3	Home health care (cost share per visit)	20%		\$45	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$50		\$50	
other special health needs	Skilled nursing care	20%	X	20%	Х
noutili necus	Durable medical equipment	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				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth			. to shargo	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	2007		See 2020 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		Schedule	
	Crowns and Casts				
Child Dantal	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2020 Dental Copay Schedule	
Services	Prosthodontics			35.1533.5	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics				, ,	

Date: March 1	4, 2019 May 16, 2019			
•	nefits and Coverage	CCSB-o		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	HDHP PI		
Actuarial Value - A	V Calculator	71.3%		
	Plan design includes a deductible?	Yes, integr		
	Integrated Individual deductible	\$2,500 integ		
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 integrated N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A		
	Individual Out-of-pocket maximum	\$6,850)	
	Family Out-of-pocket maximum	\$13,70		
	HSA plan: Self-only coverage deductible	\$2,500)	
	HSA family plan: Individual deductible	See endn	ote	
Common Medical Event	Service Type	Member Cost Share	Deductible Appli	
	Primary care visit to treat an injury, illness, or condition	20%	Х	
Health care provider's office or	Other practitioner office visit	20%	Х	
clinic visit	Specialist visit	20%	Х	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	20%	Х	
Tests	X-rays and Diagnostic Imaging	20%	Х	
	Imaging (CT/PET scans, MRIs)	20%	X	
		20% up to \$250 per		
	Tier 1	script	Х	
Drugs to	Tier 2	20% up to \$250 per script	Х	
treat illness or condition	Tier 3	20% up to \$250 per	Х	
		script	,	
	Tier 4	20% up to \$250 per script	X	
	Surgery facility fee (e.g., ASC)	20%	Х	
Outpatient services	Physician/surgeon fees	20%	Х	
33.1.333	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	
attention	Urgent care	20%	X	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X X	
Mental				
health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient	20%	Х	
substance abuse needs	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%	X	
Child ava	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		No charge		
Preventive	Sealants per Tooth Topical Elugide Application			
	Topical Fluoride Application			
Child Dental	Space Maintainers - Fixed			
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	Silver P	lan	Silver Plan	
lember Cost Share	amounts describe the Enrollee's out of pocket costs.	100%-150%		150%-200% FPL	
ctuarial Value - A	V Calculator	94.5%	6	87.7%	
	Plan design includes a deductible?		Pharmacy	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A N/A		N/A N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$1,400 / \$100 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$2,800 / \$200 / \$0	
	Individual Out-of-pocket maximum			\$2,700	
	Family Out-of-pocket maximum	\$2,00	0	\$5,400	
	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	Specialist visit	\$8		POF	
CIIIIC VISIL					
	Preventive care/ screening/ immunization	No charge			
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$8 \$8			
.0313	Imaging (CT/PET scans, MRIs)				
		\$50		\$2,700 \$5,400 N/A N/A Member Cost Share	
	Tier 1	\$3		\$5	
Drugs to	Tier 2	\$10		\$25	Pharmacy deductible
treat illness or condition	Tier 3	\$15		\$45	Pharmacy
		10% up to \$150 per			deductible Pharmacy
	Tier 4	script			deductible
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
Need immediate attention	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	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)	10%			
Mental	Physician/surgeon fee	10%		15%	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
behavioral 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 other special	Skilled nursing care	10%	X	15%	Х
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge			
Childens	Eye exam	No charge		-	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge			
	Oral Exam	5 5.10.90		. 10 0.1.2.90	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth Topical Fluoride Application				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed Restorative Procedures				
Basic		20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
Child	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
ctuarial Value - A	V Calculator	73.873.9%	
	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	\$3,700 / \$275 / \$6	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$550 / \$6	0
	Individual Out-of-pocket maximum	\$6,550 <u>\$6.500</u>	
	Family Out-of-pocket maximum	\$13,100\$13,000	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib 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	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharma
		Ψισ	deductib
Drugs to	Tier 2	\$55	Pharma deductib
treat illness or condition	Tier 3	\$85	Pharma
			deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	·		
Need immediate	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	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%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
behavioral health, or	Mental/behavioral health and substance use disorder other outpatient		
substance 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	Skilled nursing care	20%	Х
other special 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		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
Children	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		

Medically necessary orthodontics

50%

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plai	n
ctuarial Value - A	V Calculator	61.3 <u>61.4</u> %		62.0 62.1%	, 0
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integrat	ted
	Integrated Individual deductible	N/A		\$ 6,950 \$6,900 inte	-
	Integrated Family deductible	N/A	20	\$13,900 <u>\$13,800</u> integrate	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$ \$12,600 / \$1,000		N/A N/A	
	Individual Out-of-pocket maximum	\$7,850\\$7,800		\$6,950 <u>See end</u>	dnote
	Family Out-of-pocket maximum	\$15,700 <u>\$15,60</u>		\$13,900 <u>See en</u>	
	HSA plan: Self-only coverage deductible	N/A		\$6,950 <u>\$6,9</u> 6	
	HSA family plan: Individual deductible	N/A		\$ 6,950 \$6,90	<u>00</u>
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	Х
Health care provider's	Other practitioner office visit	\$65	After 1st three non-	0%	X
office or		φοσ	preventive visits After 1st three non-	070	
clinic visit	Specialist visit	\$95	preventive visits	0%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	Х
Tests	X-rays and Diagnostic Imaging	40%	X	0%	Х
	Imaging (CT/PET scans, MRIs)	40%	X	0%	Х
	Tier 1	\$18	Pharmacy Deductible	0%	Х
Daving (Tier 2	40% up to \$500 per script after	Pharmacy	OP/	
Drugs to treat illness or condition	Tier 3	pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy	0%	X
Outpatient	Tiol 3	pharmacy deductible	Deductible	0 %	^
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient services	Physician/surgeon fees	40%	X	0%	Х
Services	Outpatient visit	40%	X	0% 0% 0% 0%	X
Need	Emergency room facility fee (waived if admitted)	40%	X	0%	×
	Emergency room physician fee (waived if admitted)	No charge		0%	X
immediate attention	Medical transportation (including emergency and non-emergency)	40%	×	0%	X
attention	Urgent care	\$65	After 1st three non-	0%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		preventive visits		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	40% 40%	X	0%	X
Mental					
health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	Х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	Х	0%	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	X	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	Х
recovering or other special	Skilled nursing care	40%	×	0%	Х
health needs	Durable medical equipment	40%	×	0%	X
	Hospice service	No charge		0%	X
Obild are	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		onargo	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth Topical Fluorida Application				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
tuarial Value - A	V Calculator		
	Plan design includes a deductible?		integrated
	Integrated Individual deductible		,150 integrated
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$16,400 <u>\$1</u>	6,300 integrated
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	\$8,2	200 <u>\$8,150</u>
	Family Out-of-pocket maximum		100\$16,300
	HSA plan: Self-only coverage deductible		N/A
-	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Appli
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three n preventive visi
Health care provider's	Other practitioner office visit	0%	After 1st three r
office or	Specialist visit	0%	X X
CIINIC VISIT	Preventive care/ screening/ immunization		^
	Laboratory Tests	No charge 0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
30.3	Imaging (CT/PET scans, MRIs)	0%	×
	Tier 1	0%	X
Drugs to treat illness or condition	Tier 2	0%	X
	Tier 3	0%	X
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient services	Physician/surgeon fees	0%	Х
	Outpatient visit	0%	Х
	Emergency room facility fee (waived if admitted)	0%	Х
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	0%	Х
	Urgent care	0%	After 1st three r
	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		070	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three n preventive visi
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	X
abuse needs	items and services	070	^
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye	Eye exam	No charge	
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	
revenuve	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	0%	X
	Crowns and Casts		
A	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	0%	Х
Services	Prosthodontics		
	Oral Surgery		
Child			

9.5 EHB Date: March 14, 2019 May 16, 2019

Summary of Benefits and Coverage



Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance		Platinum Copay Pla	
Actuarial Value - A\	√ Calculator	91.7%	1 1011	89.1%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
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	¢15		¢15	
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	
		φΌ		φο	
Drugs to treat	Tier 2	\$15		\$15	
illness or condition	Tier 3	\$25		\$25	
	10.0				
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services					
	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, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
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 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				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		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				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics	Modically 1100055ally Olthodolinos	Not Covered		Not Covered	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only	Gold	Individual-only	y Gold
		Coinsurance		Copay Pla	ın
Actuarial Value - A	v Calculator Plan design includes a deductible?	81.9<u>81.8</u>% No	1	78.3%	
	Integrated Individual deductible \$0			No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$7,85 0 <u>\$7,8</u> 6	<u>)0</u>	\$7,850 <u>\$7,8</u>	<u>00</u>
	Family Out-of-pocket maximum	\$15,700 <u>\$15,6</u>	<u> </u>	\$15,700 <u>\$15,</u>	600
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Heelth sons	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's office or	Other practitioner office visit	\$30		\$30	
clinic visit	Specialist visit	\$ 6 0 <u>\$65</u>		\$ 6 0 <u>\$65</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$30		\$30	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%		\$600 per day up to	
Hospital stay	Physician/surgeon fee	20%		5 days No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$30		\$30	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30		\$30	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
recovering or 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	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				
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
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 Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics	2. 23.0.00		2. 23.0.00	
	Oral Surgery				
Child		N-+ O		Not O	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

Summary of Ben	summary of Benefits and Coverage		CCSB-only Gold		
Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan		Gold Copay Plan	
Actuarial Value - A\	/alue - AV Calculator		78.1%		
	Plan design includes a deductible?	Yes, Medical/Pharma	acy	Yes, Medical/Pharmacy	
	Integrated Individual deductible	N/A N/A		N/A N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$250 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$500 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,85 0 <u>\$7,800</u>		\$7,8 50 <u>\$7,800</u>	
	Family Out-of-pocket maximum	\$15,700 <u>\$15,600</u>		\$15,700 <u>\$15,60</u>	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	\$25		\$25	
Health care provider's	Other practitioner office visit	\$25		\$25	
office or clinic visit	Specialist visit	\$50		\$50	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$25	
Tests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$50	
illness or condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient	Physician/surgeon fees	20%		\$40	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$250	X	\$250	Х
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	x
	Urgent care	\$25		\$25	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X	\$600 per day up to 5 days	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X	No charge	,
Mental health,	Mental/behavioral health and substance use disorder outpatient office			40-	
behavioral health, or	visits	\$25		\$25	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$25	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$30		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$25	
recovering or	Skilled nursing care	20%	X	\$300 per day up to 5 days	x
other special health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Obild are	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 Preventive	Sealants per Tooth	Not Covered		Not Covered	
rieventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	N-t O		N-t O	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

	4, 2019 May 16, 2019 nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	Plan
Actuarial Value - A	V Calculator	71.7 71.8%	
	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 Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$ \$8,000 / \$600 / \$	
	Individual Out-of-pocket maximum	\$ 7,850 \$7,800	
	Family Out-of-pocket maximum	\$15,700 <u>\$15,600</u>	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit	\$40	
office or clinic visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmacy
		φισ	deductible
Drugs to treat illness or	Tier 2	\$60	Pharmacy deductible
condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
00111000	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$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%	
Mantal basith	Mental/behavioral health and substance use disorder outpatient office	2070	
Mental health, behavioral	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	
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	NI-4 Ov	
and Preventive	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	
CCGO!!!!!C3			

9.5 EHB

Part	Summary of Ben	Summary of Benefits and Coverage		CCSB-only		CCSB-only		
Print or part of the control of the	Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan					
Programme for control should be a shared with a first proport of March Foreign of Engineer (First proport) (March Foreign of Engineer)	Actuarial Value - A\	ctuarial Value - AV Calculator		70.5%		70.2%		
International department of the process of the control of the process of the proc		Plan design includes a deductible?	Yes, Medical/Pharma	псу	y Yes, Medical/Pharmacy			
Increased receased in, NOI improved Meteral / Perumony Ortinal Family consolidation, NOI improved Meteral / Perumony Ortinal Andread No. 4 process and services a								
Penity ceducition, NOT inegrated Medical Previously Terminal Products of Control 10 \$4.500.0500.20 \$4.								
Tests Common Control (Control of the Control of the								
Programmer Pro					. ,	U		
Michael Event Michael Even								
December								
Personal Content Personal Co		HSA family plan: Individual deductible	N/A		N/A			
Seath care Chick providers of cline visit Specialist visit Spe		Service Type	Member Cost Share		Member Cost Share			
providers of clinic or cli		Primary care visit to treat an injury, illness, or condition	\$50		\$50			
Ordino Vall Preventive care of seconding immunisation immu		Other practitioner office visit	\$50		\$50			
Preventive care accentring instrustization Prove of the care accentring instrustization Laboratory releas Laboratory releas Laboratory releas Laboratory releas Laboratory releas Ter 4 Laboratory releas Laboratory releas Laboratory releases Ter 4 Laboratory releases Ter 4 Laboratory releases Laboratory releases Ter 4 Laboratory releases Laboratory	office or							
Lebrository Technology	clinic visit				·			
Tests X-rays and Diagnostic Invaging \$85 \$300 \$3		•	-					
Test 1	T							
Tier 1 517 controlled 518 controlled	lests							
The 1 of the condition		Imaging (CT/PET scans, MRIs)	20%	Dharmani	\$300	Dharmani		
True 3 800 documents of control influence or contro		Tier 1	\$17		\$17			
Tier 3 Tier 4 Tier 4 20% to 10 5250 per sorter after pharmacy cloud-tible 20% to 10 5250 per sorter after pharmacy cloud-tible 20% to 10 5250 per sorter after pharmacy cloud-tible 20% to 20% to 20% to 20% to 20% to 20% to 10 5250 per sorter after pharmacy cloud-tible 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%	Drugs to treat	Tier 2	\$65		\$65			
The 4 20% up to \$250 per accept after phurmacy ordustration phurmacy ordustration phurmacy ordustration phurmacy ordustration or phurmacy ordustration phurmacy ordustration phurmacy ordustration or phurmacy ordustration phurmacy ordustration phurmacy ordustration or phurmacy ordustration phurmacy ordustration or phurmacy ordustration phurmacy ordustration or phurmacy ordustration or phurmacy ordustration phurmacy ordustration phurmacy ordustration or phurmacy ordustration phurmacy ordustration or phurmacy ordustrati		Tion 2	# 00		#00			
Couparisers Sugrey facility fre (e.g., ASC) Physican/surgoon fees Outpatient visit Emergency controlling foe (wived if admitted) Need Immediate attention Need Immediate attention Urgent care Resignify fre (e.g., Decipital norm) for inputient stay (including steepency) Urgent care Resignify fre (e.g., Decipital norm) for inputient stay (including steepency) Virgent care Resignify fre (e.g., Decipital norm) for inputient stay (including steepency) No charge Mental health, pre-lately and substance use disorder outpatient office visits Mental health, the stay or autostance Services Pregnancy Pregnancy Pregnancy Preventive Child Operation Child	Condition	Hel 3						
Outpatient Network Services Outpatient visit Demogracy room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) No charge Regregatory room facility fee (waived if admitted) No charge Regregatory come facility fee (waived if admitted) Urgent care Urgent care SSO SSO SSO SSO Watter of the facility fee (e.g., Inceptial score) for impatient stay (including lateor and delivery, metral health, and substance use) Wental health, behavioral health and substance use disorder outpatient office works abuse needs Watter needs Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Presental care and proconception visits No charge Home health care (cost share per visit) Outpatient Retrabilitation and Habilitation services Side outpatient facility and Habilitation and Habilitation services Side outpatient facility and Habilitation services No charge No charge No charge No charge Orable medical equipment 20% X 20% X 20% X AV AV AV AV AV AV AV AV AV		Tier 4						
Services Physical surgeon feels 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%		Surgery facility fee (e.g., ASC)	20%		20%			
Outpatient visit Rend Emergency prom facility fee (waived if admitted) No charge Rend Immediate attention William (See Control of Control of Covered Information of Covered Informa		Physician/surgeon fees	20%		20%			
Need Immediate		Outpatient visit	20%		20%			
immediate attention Medical transportation (including emergency) Urgent care Facility (see (e.g. brospital room) for impatient stay (including labor and divilency, mental health, and substance use) Physician-bravioral health, or substance behavioral health, or substance abuse needs Pregnancy Pregnancy Pregnancy Prenstal care and preconception visits No charge No charge No charge No charge No charge No charge Side examination and Habilitation services Side of the Holp recovering or other special health needs Child eye care Child Dental bigses per year (or contact lenses in lieu of glasses) Child Dental Diagnostic and Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Preventive Child Dental Basic Services Crowns and Casts Child Dental Major Services Preventive Child Dental Major Services Oral Exam Preventive - Cleaning Preventive Child Dental Major Services Predodortics Oral Susmer Previous control of the		Emergency room facility fee (waived if admitted)	\$400	X	\$400	Х		
Medical transportation (including emergency and non-emergency) \$250		Emergency room physician fee (waived if admitted)	No charge		No charge			
Hospital stay Procling fee (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Mental health, behavioral health and substance use disorder outpatient office visits Pregnancy Pregnancy Prematal care and preconception visits No charge Skilled nursing care Durable medical equipment Hospics service Child eye Gare Child Dental Diagnostic and Preventive Child Dental Salasic Services Preventive Child Dental Major Corvors and Casts Findodontics Child Datal Major Services Periodontics (other than maintenance) Prediodontics Oral Expression of the periodontics of the following of the periodontics of the following of the periodontics of the periodontics Oral Expression of the periodontics Oral Expression of the periodontics of the periodontics of the periodontics Oral Surgery Oral Expression of the periodontics		Medical transportation (including emergency and non-emergency)	\$250	X	\$250	Х		
Hospital stay delivery, mental health, and substance use) 20% X 20		Urgent care	\$50		\$50			
Hospital stay Physician/suppone fee Physician/suppone fee Physician/suppone fee Physician/suppone fee Physician/suppone fee Physician/suppone fee Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient tiems and services Pregnancy Prenantal care and preconception visits No charge No charge No charge No charge No charge No charge Skilled nursing care Durable medical equipment Lohid eye care Child eye care Child Dental Diagnostic and Preventive Child Dental Diagnostic and Preventive Child Dental Diagnostic Services Restorative Procedures Services Periodontics Child Dental Major Services Crows and Casts Endodontics Previous (other than maintenance) Previous Previous Previous Not Covered			20%	X	20%	Х		
Mental health, behavioral health and substance use disorder outpatient office visits S50 S	Hospital stay							
behavioral health, or substance abuse needs Pregnancy Prental care and preconception visits Home health care (cost share per visit) Cutpatient Rehabilitation and Habilitation services S50 No charge No charge No charge No charge No charge No charge S50 S50 S50 Pregnancy Prental care and preconception visits No charge No charge Skilled nursing care Durable medical equipment Hospice service No charge No ch			2078	^	2076			
Substance Abustance Abus	behavioral	· ·	\$50		\$50			
Holp recovering or other special health care (cost share per visit) Holp recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child deve care Child Dental Diagnostic and Preventive Preventive Child Dental Basic Services Crowns and Casts Endodorntics Oral Surgery Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically recessary orthodontics Not Covered			\$50		\$50			
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Preventive Child Dental Basic Services Child Dental Basic Services Child Dental Basic Services Child Dental Basic Services Crowns and Casts Endodontics Crowns and Casts Endodontics Oral Surgery Child Dental Major Services Crown Services Preventive Than Major Services Previodontics (other than maintenance) Prosthodontics Oral Surgery Crown Services Not Covered	Pregnancy	Prenatal care and preconception visits	No charge		No charge			
Skilled nursing care other special health needs Durable medical equipment Hospice service Child eye care Child bental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Correct Maintenance Services Skilled nursing care 20% X 20% X 20% No charge No char		Home health care (cost share per visit)	20%		\$45			
recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Crowns and Casts Endodontics Oral Surgery Child Dental Major Services Oral Surgery Child Dental Major Services Not Covered	Help	Outpatient Rehabilitation and Habilitation services	\$50		\$50			
health needs health needs Durable medical equipment Hospice service Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge No charge No charge Child Dental Diagnostic and Preventive Not Covered Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Crows and Casts Endodontics Prosthodontics Oral Surgery Child Medically recessary orthodortics Oral Surgery Not Covered Not Covered	recovering or	Skilled nursing care	20%	X	20%	X		
Hospice service Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Madrically peressay orthodontics Oral Surgery No charge N			20%		20%			
Child Dental Diagnostic and Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically perassage orthodontics Not Covered Not Covered Not Covered Not Covered Not Covered								
Child Dental Dajonostic and Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Exam Not Covered	01.11				-			
Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered			_		_			
Child Dental Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Maintenance Services Child Dental Major Services Not Covered Not Cov			140 ondigo		140 ondigo			
Child Dental Diagnostic and Preventive Preventive - X-ray Not Covered Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Not Covered Child Dental Basic Services Restorative Procedures Periodontal Maintenance Services Not Covered Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered								
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics Oral Surgery Child Medically pecessary orthodoptics Not Covered		·						
Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered Not Covered Not Covered Not Covered Not Covered			Not Covered		Not Covered			
Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Preventive	·						
Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered								
Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered	Child Dental							
Crowns and Casts Endodontics Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered	Basic		Not Covered		Not Covered			
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered Not Covered	Services							
Child Dental Major Periodontics (other than maintenance) Services Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered Not Covered								
Services Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered								
Oral Surgery Child Medically necessary orthodontics Not Covered Not Covered			Not Covered		Not Covered			
Child Medically necessary orthodontics Not Covered Not Covered								
	Chira	Oral Surgery						
		Medically necessary orthodontics	Not Covered		Not Covered			

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Date: March 1	4 , 2019 May 16, 2019			
-	efits and Coverage	CCSB-o Silver	•	
Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	HDHP P		
Actuarial Value - A\	/ Calculator	71.3%		
	Plan design includes a deductible?			
	Integrated Individual deductible	\$2,500 integ		
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 integ	grated	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A		
	Individual Out-of-pocket maximum	\$6,850)	
	Family Out-of-pocket maximum	\$13,70	0	
	HSA plan: Self-only coverage deductible	\$2,500)	
	HSA family plan: Individual deductible	See endr	note	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	20%	x	
Health care provider's office or	Other practitioner office visit	20%	X	
clinic visit	Specialist visit	20%	X	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	20%	Х	
Tests	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
	Tier 1	20% up to \$250 per script	X	
Drugs to treat	Tier 2	20% up to \$250 per	x	
illness or condition	Tier 3	script 20% up to \$250 per	x	
	Tier 4	script 20% up to \$250 per	x	
	Surgery facility fee (e.g., ASC)	script	X	
Outpatient	Physician/surgeon fees	20%	X	
services	Outpatient visit	20%	X	
	Emergency room facility fee (waived if admitted)	20%	X	
Need	Emergency room physician fee (waived if admitted)	0%	x	
immediate attention	Medical transportation (including emergency and non-emergency)	20%	X	
attention	Urgent care	20%	x	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			
Hospital stay	delivery, mental health, and substance use)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	X	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
3,	Home health care (cost share per visit)	20%	X	
Heli	Outpatient Rehabilitation and Habilitation services	20%	x	
Help recovering or				
other special health needs	Skilled nursing care	20%	X	
	Durable medical equipment	20%	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		
	Oral Exam	No charge		
	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	Periodontal Maintenance Services	Not Covered		
Services	Periodontal Maintenance Services Crowns and Casts			
	Endodontics			
Child Dental		Not Cover-		
Major Services	Periodontics (other than maintenance) Prosthodontics	Not Covered		
Child	Oral Surgery	N : O		
Orthodontics	Medically necessary orthodontics	Not Covered		

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
tuarial Value - AV	/ Calculator	94.5%		87.7%	
	Plan design includes a deductible?	Yes, Medical/F	harmacy	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	\$1,400 / \$100 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$2,800 / \$200 / \$0)
	Individual Out-of-pocket maximum	\$1,000)	\$2,700	
	Family Out-of-pocket maximum	\$2,000)	\$5,400	
	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	Deductil Applie
	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		\$20	
Гests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1			\$5	
		\$3			Pharm
Orugs to treat	Tier 2	\$10		\$25	deduct
ondition	Tier 3	\$15		\$45	deduct
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharm deduct
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient ervices	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
leed	Emergency room physician fee (waived if admitted)	No charge		No charge	
mmediate attention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		.,	·	.,
lospital stay	delivery, mental health, and substance use)	10%	X	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	
lalm	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
lelp ecovering or	·				
ther special lealth needs	Skilled nursing care	10%	Х	15%	Х
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child 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				
Child Danta	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
nd Preventive	Sealants per Tooth	oovoicu		1101 0010100	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	N O		N. O	
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				

9.5 EHB

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
tuarial Value - A\	/ Calculator	73.8 <u>73.9</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	\$3,700 / \$275 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental \$7,400 / \$550		\$7,400 / \$550 / \$	0
	Individual Out-of-pocket maximum	\$ 6,5 50 <u>\$6,500</u>	
	Family Out-of-pocket maximum	\$13,100 <u>\$13,000</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib 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	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharma
Drugs to treat	Tier 2	\$55	deductik Pharma
Illness or condition	Tier 3	\$85	deductik Pharma
		20% up to \$250 per script	deductil Pharma
	Tier 4	after pharmacy deductible	deductil
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35	
Haanital atau	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
Hospital stay	Physician/surgeon fee	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$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	Skilled nursing care	20%	X
other special 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	140 Glarge	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive	·		
	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
23.1.300	Crowns and Casts		
01.11.5	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

lember Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze	
ctuarial Value - A\	/ Calculator	61.3 61.4%		HDHP Pla 62.062.1	
otaanai valao 700	Plan design includes a deductible? Yes, Medical/Pharmacy		Yes, integra		
	Integrated Individual deductible N/A		\$6,950 <u>\$6,900</u> in		
	Integrated Family deductible N/A		\$13,900 <u>\$13,800</u> integ		
	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	\$ 7,850 \$ <u>7,800</u>		\$6,950 <u>See er</u>	ndnote
	Family Out-of-pocket maximum	\$15,700 <u>\$15,60</u>	<u>0</u>	\$13,900 <u>See e</u>	
	HSA plan: Self-only coverage deductible	N/A		\$6,950 <u>\$6,9</u>	
	HSA family plan: Individual deductible	N/A		\$6,950 <u>\$6,9</u>	900
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	Х
Health care	Other practitioner office visit	\$65	After 1st three non-	0%	X
provider's office or	Carlot practitioned critical visit	φοσ	preventive visits After 1st three non-	078	_ ^
clinic visit	Specialist visit	\$95	preventive visits	0%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	Х
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	Х
	Tier 1	\$18	Pharmacy Deductible	0%	Х
Drugs to treat	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X
illness or		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy		
condition	Tier 3	pharmacy deductible	Deductible	0%	X
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient	Physician/surgeon fees	40%	X	0%	X
services	Outpatient visit				
		40%	X	0%	X
No. 1	Emergency room facility fee (waived if admitted)	40%	X	0%	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge		0%	X
attention	Medical transportation (including emergency and non-emergency)	40%	X After 1st three non-	0%	X
	Urgent care	\$65	preventive visits	0%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	Х
110Spital Stay	Physician/surgeon fee	40%	X	0%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	X
behavioral health, or	VISILS		preventive visits		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	X	0%	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	X	0%	X
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	X
recovering or other special	Skilled nursing care	40%	×	0%	X
health needs	Durable medical equipment	40%	x	0%	X
	Hospice service	No charge		0%	X
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	140 Sharge		. to onarge	
	Preventive - Cleaning				
Child Dental					
Diagnostic and	Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Child Day	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
CEI VICES	Crowns and Casts				
Child Dental	Endodontics	Net O		Net O	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
01.11.1	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

Date: March 14, 2019 May 16, 2019

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
Individual deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Individual Out—of—pocket maximum
Family Out-of-pocket maximum
Family Out-of-pocket maximum
\$8,200\sum_{8,150}\$ integrated
\$16,400\sum_{16,300}\$ integrated

N/A

N/A

\$8,200\sum_{8,150}\$ integrated

	Family deductible, NOT integrated. Medical / Pharmacy / Dental		IN/A
	Individual Out-of-pocket maximum	\$8,2	2 00 \$8,150
	Family Out-of-pocket maximum	\$16, -	100 \$16,300
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no
Health care provider's	Other practitioner office visit	0%	After 1st three no
office or clinic visit	Specialist visit	0%	×
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	х
Drugs to treat	Tier 2	0%	Х
condition	Tier 3	0%	X
	Tier 4	0%	x
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient services	Physician/surgeon fees	0%	Х
services	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
Need	Emergency room physician fee (waived if admitted)		Α
immediate		No charge	
attention	Medical transportation (including emergency and non-emergency)	0%	X After 1st three no
	Urgent care	0%	preventive visit
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	Х
nospitai stay	Physician/surgeon fee	0%	Х
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visit
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%	X
recovering or	Skilled nursing care	0%	X
other special health needs	·		
	Durable medical equipment	0%	Х
	Hospice service	0%	Х
Child eye care	Eye exam 1 pair of glasses per year (or centest lenges in liquid glasses)	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic and	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		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child		Not Course	
Orthodontics	Medically necessary orthodontics	Not Covered	

Endnotes to Covered California 2020 Patient-Centered Benefit Plan Designs

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

Notes:

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

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 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. New preferred brands.
	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
2	3) Any other drugs recommended by the plan's
	pharmaceutical and therapeutics (P&T) committee based on
	drug safety, efficacy and cost.
	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based
3	on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	1) 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
4	clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than
	six hundred dollars (\$600) net of rebates for a one-month
	supply.

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

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

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