Covered California 2018 Patient-Centered Benefit Plan Designs¹

Final Board-approved March 14, 2017²

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

² Clerical adjustment made to the AV for Silver 87 on March 21, 2017 to reflect final AV certification; adjustment made on April 18, 2017 to correctly reference the 2018 Dental Copay Schedule rather than the 2017 Schedule

³ Deductible limit for an individual in a family in the CCSB Silver HDHP plan changed on May 16, 2017 to comply with Revenue Procedure 2017-37 issued by the IRS on May 4, 2017



Member Cost Share amounts describe the Enrollee's out of pocket costs.			Platinum		Platinu	
Actuarial Value - AV Calculator			Coinsurance Plan 91.2%		Copay Plan 88.1%	
	cludes a deductible?		No	,	No	
Integrated Inc	dividual deductible		\$0		\$0	
	ımily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$0 \$0 / \$0 / \$0		\$0 \$0 / \$0 /	\$0
Family deduc	ctible, NOT integrated: Medica -of-pocket maximum		\$0 / \$0 / \$0 \$3,350		\$0 / \$0 / \$3,350	
Family Out-of-	pocket maximum		\$6,70		\$6,700	
	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$15		\$15	
Health care provider's office or clinic	Other practitioner office visit		\$15		\$15	
visit	Specialist visit		\$30		\$30	
	Preventive care/ screening/ im Laboratory Tests	munization	No charge \$15		No charge \$15	
Tests	X-rays and Diagnostic Imaging		\$30		\$30	
	Imaging (CT/PET scans, MRIs		10%		\$75	
	Tier 1		\$5		\$5	
Drugs to treat	Tier 2		\$15		\$15	
condition	Tier 3	\$25		\$25		
	Tier 4 Surgery facility fee (e.g., ASC)		10% up to \$250 per script		10% up to \$250 per script \$100	
Outpatient services	Physician/surgeon fees		10%		\$25	
Sel Vices	Outpatient visit		10%		10%	
	Emergency room facility fee (w	aived if admitted)	\$150		\$150	
Need	Emergency room physician fee (waived if admitted)		No charge		No charge	
immediate	Emergency medical transporta	tion	\$150		\$150	
attention	Urgent care		\$15		\$15	
	Facility fee (e.g. hospital room) Physician/surgeon fee		10%		\$250 per day up	
Hospital stay			10%		to 5 days No charge	
	Mental/Behavioral health outpatient office visits		\$15		\$15	
	Mental/Behavioral health other outpatient items and services		\$15		\$15	
Mental health,	Mental/Behavioral health inpat	10%		\$250 per day up to 5 days		
behavioral	Mental/Behavioral health inpatient physician fee		10%		No charge	
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$15		\$15	
	Substance Use disorder other outpatient items and services		\$15		\$15	
	Substance Use inpatient facility	y fee (e.g. hospital room)	10%		\$250 per day up	
			10%		to 5 days	
	Substance use disorder inpatie Prenatal care and preconcepti		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	No charge		\$250 per day up	
ganoy	services	Professional	10%		to 5 days No charge	
	Home health care (cost share	per visit)	10%		\$20	
Help	Outpatient Rehabilitation services Outpatient Habilitation services		\$15 \$15		\$15 \$15	
recovering or other special	Skilled nursing care		10%		\$150 per day up	
health needs	Durable medical equipment		10%		to 5 days 10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or co	antact laneae in liqu of alacees	No charge No charge		No charge No charge	
	Oral Exam	ortact tenses in fleu of glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed	ace Maintainers - Fixed				
Basic	Restorative Procedures		20%		See 2018 Dental Copay Schedule	
Services	Periodontal Maintenance Serv	ces			, Lp 3, Johnstone	
Child Dental	Crowns and Casts Endodontics					
Major	Periodontics (other than mainte	enance)	50%		See 2018 Dental Copay Schedule	
Services	Prosthodontics				Jopay Juleuule	
	Oral Surgery					
Child Orthodontics	Medically necessary orthodont	ics	50%		\$1,000	

Summary of	Benefits and Coverage		0.1		0.11	
	hare amounts describe the En	rollee's out of pocket costs.	Coinsurand	ce Plan	Gold Copay F 78.4%	lan
	cludes a deductible?		No	•	No.47	,
Integrated In	dividual deductible		\$0 \$0		\$0 \$0	
Individual de	ductible, NOT integrated: Me		\$0 / \$0		\$0 / \$0 /	
Individual Out-	ctible, NOT integrated: Medic -of-pocket maximum	ai / Pharmacy / Dentai	\$0 / \$0 / \$6,00	0	\$0 / \$0 / \$6,000)
	pocket maximum -only coverage deductible		\$12,00 N/A	00	\$12,00 N/A	0
HSA family pla	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in		\$25		\$25	
Health care provider's	Other practitioner office visit		\$25		\$25	
office or clinic visit	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
	Laboratory Tests		\$35		\$35	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$55 20%		\$55 \$275	
	Tier 1		\$15		\$15	
Drugs to treat illness or	Tier 2		\$55		\$55	
condition	Tier 3		\$75		\$75	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%		\$300 \$40	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (v	vaived if admitted)	\$325		\$325	
Need	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
immediate attention	Emergency medical transporta	ation	\$250		\$250	
attention	Urgent care		\$25		\$25	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
nospital stay	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health outp	atient office visits	\$25		\$25	
	Mental/Behavioral health othe	r outpatient items and services	\$25		\$25	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%		No charge	
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$25		\$25	
	Substance Use disorder other	outpatient items and services	\$25		\$25	
		•			\$600 per day up	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%		to 5 days	
	Substance use disorder inpati	ent physician fee	20%		No charge	
	Prenatal care and preconcept		No charge		No charge \$600 per day up	
Pregnancy	Delivery and all inpatient services	Hospital	20%		to 5 days	
	Home health care (cost share		20%		No charge \$30	
Help	Outpatient Rehabilitation serv Outpatient Habilitation service		\$25 \$25		\$25 \$25	
recovering or other special	Skilled nursing care		20%		\$300 per day up to 5 days	
health needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam					
Diagnostic	Preventive - Cleaning Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		. 10 Sharge		. 10 ondige	
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		20%		See 2018 Dental Copay Schedule	
Services	Periodontal Maintenance Serv Crowns and Casts	rices			Jopay Gorieudie	
Child Dental	Endodontics					
Major	Periodontics (other than main	enance)	50%		See 2018 Dental Copay Schedule	
Services	Prosthodontics Oral Surgery		-			
Child Orthodontics	Medically necessary orthodon	tics	50%		\$1,000	

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver Plan	1
Actuarial Value	- AV Calculator	71.9%	
Plan design inc	cludes a deductible?	Yes, Medical/Pha	armacy
	dividual deductible	N/A	
	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$2,500 / \$130	/ \$0
Family deduc	tible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$260	
	-of-pocket maximum	\$7,000 \$14,000	
	pocket maximum -only coverage deductible	\$14,000 N/A	
HSA family pla	n: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's office or clinic	Other practitioner office visit	\$35	
visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$35	
resis	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$75 \$300	
	Tier 1	\$15	Pharmacy
Drugs to treat	Tier 2	\$55	Pharmacy
illness or			deductible
condition	Tier 3	\$80	Pharmacy
	Tier 4 Surgery facility fee (e.g., ASC)	20% up to \$250 per script after pharmacy deductible 20%	Pharmacy deductible
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate attention	Emergency medical transportation	\$250	Х
	Urgent care	\$35	X
Hospital stay	Facility fee (e.g. hospital room)	20%	X
riospitai stay	Physician/surgeon fee	20%	Х
	Mental/Behavioral health outpatient office visits	\$35	
	Mental/Behavioral health other outpatient items and services	\$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$35	
	Substance Use disorder other outpatient items and services	\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient physician fee	20%	Х
D	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient services Hospital	20%	Х
	Professional Home health care (cost share per visit)	20% \$45	X
Help	Outpatient Rehabilitation services	\$35	
recovering or	Outpatient Habilitation services	\$35	
other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service Eye exam	No charge No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	Ů.	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

Summary of Benefits and Coverage			CCSB		CCSB			
Member Cost S	Member Cost Share amounts describe the Enrollee's out of pocket costs.			Silver Coinsurance Plan		Silver Copay Plan		
Actuarial Value - AV Calculator			71.9%		71.4%			
	cludes a deductible? dividual deductible		Yes, Medical/Pharmacy N/A		Yes, Medical/Pharmacy N/A			
Integrated Fa	amily deductible ductible, NOT integrated: Me	edical / Pharmacy / Dental	N/A \$2,000 / \$125	i / \$0	N/A \$2,000/ \$125	/\$0		
Family deduc	ctible, NOT integrated: Medic		\$4,000 / \$250		\$4,000 / \$250			
Family Out-of-	of-pocket maximum pocket maximum		\$7,000 \$14,000		\$7,000 \$14,000			
	only coverage deductible in: Individual deductible		N/A N/A		N/A N/A			
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies		
	Daine and a second second second	aliana illanaan araa alialan	\$45		0.45			
	Primary care visit to treat an i	njury, iliness, or condition	\$45		\$45			
Health care provider's	Other practitioner office visit		\$45		\$45			
office or clinic visit					• •			
	Specialist visit		\$75		\$75			
	Preventive care/ screening/ ir	nmunization	No charge		No charge			
Tests	Laboratory Tests X-rays and Diagnostic Imagin		\$40 \$70		\$40 \$70			
1000	Imaging (CT/PET scans, MRI		20%		\$300			
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmacy deductible		
Drugs to treat	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible			
illness or condition	Tier 3		\$85	Pharmacy	\$85	Pharmacy		
			20% up to \$250 per	deductible	20% up to \$250 per	deductible		
	Tier 4		script after pharmacy	Pharmacy deductible	script after pharmacy	Pharmacy deductible		
Outpatient	Surgery facility fee (e.g., ASC)	deductible 20%		deductible 20%			
services	Physician/surgeon fees Outpatient visit		20%		20%			
	Emergency room facility fee (waived if admitted)	\$350		\$350			
	Emergency room physician fee (waived if admitted)		No charge		No charge			
Need immediate attention	Emergency medical transport	ation	\$250	Х	\$250	X		
	Urgent care		\$45		\$45			
	Organi dare		ΨΨΟ		\$45			
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х	20%	Х		
nospital stay	Physician/surgeon fee		20%	X	20%	X		
	Mental/Behavioral health outp	patient office visits	\$45		\$45			
	nonce por a real real real real real real real r							
	Mental/Behavioral health other outpatient items and services		\$45		\$45			
	and the second s		·		·			
Mental health,	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	20%	Х		
behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х	20%	Х		
health, or substance	Substance Use disorder outpatient office visits		\$45		\$45			
abuse needs	Substance Ose disorder outp	auent onice visits	ΨΨΟ		ΨΨΟ			
	Cultura and the discourse of the		0.45		0.45			
	Substance Use disorder other outpatient items and services		\$45		\$45			
	Substance Use inpatient facil	ty fee (e.g. hospital room)	20%	Х	20%	Х		
	Substance use disorder inpat	ient physician fee	20%	Х	20%	Х		
	Prenatal care and preconcep	ion visits	No charge		No charge			
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х	20%	Х		
	Home health care (cost share	Professional per visit)	20%	X	20% \$45	X		
Help	Outpatient Rehabilitation service Outpatient Habilitation service	ices	\$45 \$45		\$45 \$45			
recovering or other special	Skilled nursing care	55	20%	Х	20%	Х		
health needs	Durable medical equipment		20%		20%			
	Hospice service Eye exam		No charge No charge		No charge No charge			
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge			
Child Dental	Oral Exam Preventive - Cleaning							
Diagnostic and	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge			
Preventive			1					
Child Dental	Space Maintainers - Fixed Restorative Procedures				See 2018 Dental Copay			
Basic Services	Periodontal Maintenance Ser	vices	20%		Schedule Schedule			
	Crowns and Casts Endodontics							
Child Dental Major	Periodontics (other than main	tenance)	50%		See 2018 Dental Copay			
Services	Prosthodontics		1		Schedule			
Child	Oral Surgery				21.221			
Orthodontics	Medically necessary orthodor	ITICS	50%		\$1,000			

Summary of	Benefits and Coverage	CCSE	
•	thare amounts describe the Enrollee's out of pocket costs.	Silver	
	e - AV Calculator	HDHP P	
	cludes a deductible?	Yes, integr	
Integrated In	dividual deductible	\$2,000 integ	grated
Individual de	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 integ N/A	grated
	ctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	N/A \$6,550)
Family Out-of-	pocket maximum	\$13,10	0
	-only coverage deductible In: Individual deductible	\$2,000 \$2,600 <u>\$2</u>	
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%	Х
	Preventive care/ screening/ immunization Laboratory Tests	No charge 20%	X
Tests	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
	Tier 1	20% up to \$250 per script	х
Drugs to treat illness or	Tier 2	20% up to \$250 per script	Х
condition	Tier 3	20% up to \$250 per script	Х
	Tier 4	20% up to \$250 per script	Х
Outpatient	Surgery facility fee (e.g., ASC)	20%	Х
services	Physician/surgeon fees Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	X
	Emergency room physician fee (waived if admitted)	0%	X
Need	Emergency medical transportation	20%	X
immediate attention	and goney modern an approximation	2070	
	Urgent care	20%	Х
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
nospital stay	Physician/surgeon fee	20%	Х
	Mental/Behavioral health outpatient office visits	20%	Х
	Mental/Behavioral health other outpatient items and services	20%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	20%	Х
health, or	Total School and Country Proposition (Country Proposition Country	2070	^
substance abuse needs	Substance Use disorder outpatient office visits	20%	Х
	Substance Use disorder other outpatient items and services	20%	Х
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient physician fee	20%	Х
	Prenatal care and preconception visits	No charge	^
Pregnancy	Delivery and all inpatient Hospital	20%	Х
	services Professional	20%	X
	Home health care (cost share per visit) Outpatient Rehabilitation services	20% 20%	X
Help recovering or	Outpatient Renabilitation services Outpatient Habilitation services	20%	X
other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	X
	Hospice service Eye exam	0% No charge	X
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application	2 2 3	
	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) Prosthodontics	50%	
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

2018 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: March 14, 2017

	hare amounts describe the En	rollee's out of pocket costs.	Silver F 100%-150 93.99	% FPL	Silver Plan 150%-200% FPL 88.0%		
Plan design ind	cludes a deductible?		Yes, Medical/		Yes, Medical/Pha	rmacy	
	dividual deductible		N/A		N/A		
	imily deductible ductible, NOT integrated: Me	edical / Pharmacy / Dental	N/A \$75 / \$0	N/A N/A 5 / \$0 / \$0 \$650 / \$50 / \$0		60	
Family deduc	ctible, NOT integrated: Medic		\$150 / \$0)/\$0	\$1,300 / \$100 /		
	-of-pocket maximum pocket maximum		\$1,00 \$2,00		\$2,450 \$4,900		
HSA plan: Self-	only coverage deductible		N/A		N/A		
HSA family pla	n: Individual deductible		N/A		N/A		
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
		TVIOC TYPO		прриос		7 ippiloo	
	Primary care visit to treat an i	njury, illness, or condition	\$5		\$10		
Haaldh assa							
Health care provider's	Other practitioner office visit		\$5		\$10		
office or clinic			·				
visit	Specialist visit		\$8		\$25		
	Specialist visit		ФО		\$25		
	Preventive care/ screening/ in	nmunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imagin	n	\$8 \$8		\$15 \$25		
16313	Imaging (CT/PET scans, MRI		\$50		\$100		
	T: 4				Φ.5		
	Tier 1		\$3		\$5		
	Ties 0		212		***	Pharmacy	
Drugs to treat	Tier 2		\$10		\$20	deductible	
illness or condition						Pharmacy	
	Tier 3		\$15		\$35	deductible	
			10% up to \$150		15% up to \$150 per	Pharmacy	
	Tier 4		per script		script after pharmacy deductible	deductible	
0	Surgery facility fee (e.g., ASC)	10%		15%		
Outpatient services	Physician/surgeon fees		10%		15%		
	Outpatient visit		10%		15%		
	Emergency room facility fee (vaived if admitted)	\$50		\$100		
Nasad	Emergency room physician fe	e (waived if admitted)	No charge		No charge		
Need immediate	Emergency medical transport	ation	\$30	X	\$75	Х	
attention							
	Urgent care		\$5		\$10		
	Facility fee (e.g. hospital room	1)	10%	Х	15%	Х	
Hospital stay	Physician/surgeon fee		10%	Х	15%	Х	
	· ···ye························g-e-·········		1070		1070		
	Mental/Behavioral health outp	atient office visits	\$5		\$10		
	Mental/Rehavioral health othe	r outpatient items and services	\$5		\$10		
	ivienta/ benavioral nealth othe	outpatient items and services	φυ		\$10		
	Mental/Behavioral health inna	tient facility fee (e.g.hospital room)	10%	Х	15%	Х	
Mental health,	· ·	, (, , ,					
behavioral	Mental/Behavioral health inpa	tient physician fee	10%	Х	15%	Х	
health, or substance			-		• • •		
abuse needs	Substance Use disorder outpo	atient office visits	\$5		\$10		
	Substance Use disorder other	outpatient items and services	\$5		\$10		
		•			• •		
	Substance Use inpatient facili	ty fee (e.g. hospital room)	10%	Х	15%	Х	
	·						
	Substance use disorder inpati		10%	Х	15%	Х	
	Prenatal care and preconcept	ion visits	No charge		No charge		
Pregnancy	Delivery and all inpatient services	Hospital	10%	Х	15%	Х	
		Professional por visit)	10%	X	15%	X	
I I a la	Home health care (cost share Outpatient Rehabilitation serv		\$3 \$5		\$15 \$10		
Help recovering or	Outpatient Habilitation service		\$5		\$10		
other special	Skilled nursing care		10%	х	15%	Х	
health needs	Durable medical equipment		10%		15%		
	Hospice service Eye exam		No charge No charge		No charge No charge		
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of plassos)	No charge		No charge		
	Oral Exam	act remove in fied of glasses)	. 40 onlarge		140 onarge		
Child Dental	Preventive - Cleaning						
Diagnostic and	Preventive - X-ray		No charge		No charge		
Preventive	Sealants per Tooth Topical Fluoride Application						
01.11.1.5	Space Maintainers - Fixed						
Child Dental Basic	Restorative Procedures		20%		20%		
Services	Periodontal Maintenance Serv	vices			2370		
	Crowns and Casts						
Child Dental	Endodontics						
Major Services	Periodontics (other than main	renance)	50%		50%		
	Prosthodontics Oral Surgery						
Child							
Orthodontics	Medically necessary orthodon	tics	50%		50%		

2018 Patient-Centered Benefit Plan Designs

Urgent care

Hospital stay

havioral

regnancy

Help recovering or other special health needs

Child eye care

Child Dental

Child Dental

Child Dental Major Services

Child Orthodontics

services

Skilled nursing care

Hospice service Eye exam

Durable medical equipment

Oral Exam
Preventive - Cleaning
Preventive - X-ray
Sealants per Tooth
Topical Fluoride Application
Space Maintainers - Fixed

Restorative Procedures

Endodontics

Prosthodontics Oral Surgery

Periodontal Maintenance Services Crowns and Casts

Medically necessary orthodontics

Periodontics (other than maintenance)

Facility fee (e.g. hospital room)

Mental/Behavioral health outpatient office visits

Mental/Behavioral health inpatient physician fee

Substance Use disorder outpatient office visits

Substance use disorder inpatient physician fee

Prenatal care and preconception visits

Delivery and all inpatient Hospital

Services Professional
Home health care (cost share per visit)
Outpatient Rehabilitation services
Outpatient Habilitation services

Mental/Behavioral health other outpatient items and services

Substance Use disorder other outpatient items and services

Substance Use inpatient facility fee (e.g. hospital room)

1 pair of glasses per year (or contact lenses in lieu of glasses)

Mental/Behavioral health inpatient facility fee (e.g.hospital room)

Physician/surgeon fee

Summary of	Benefits and Coverage		
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FP	L
Actuarial Value	- AV Calculator	73.9%	
Plan design in	cludes a deductible?	Yes, Medical/Pharr	macv
Integrated Inc	dividual deductible	N/A	,
	mily deductible	N/A	
	ductible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 / \$130 / \$ \$4,400 / \$260 / \$	
	-of-pocket maximum	\$5,850	ΦU
	pocket maximum	\$11,700	
	only coverage deductible	N/A	
HSA family pla	n: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$30	
Health care provider's office or clinic	Other practitioner office visit	\$30	
visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Tests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharmacy deductible
Drugs to treat	Tier 2	\$50	Pharmacy deductible
condition	Tier 3	\$75	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpotiont	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
JUL 71000	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Emergency room physician ree (waived ii damitted)	110 onargo	

\$30

20%

20%

\$30

\$30

20%

20%

\$30

\$30

20%

20%

No charge

20%

20% \$40 \$30 \$30

20%

20%

No charge No charge

No charge

No charge

20%

50%

50%

Х

Χ

Χ

Х

Х

Х

Х

Summary of	Benefits and Coverage					
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze HDHP Plan		
Actuarial Value - AV Calculator		60.8%		61.49	6	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, integrated		
Integrated Individual deductible		N/A		\$4,800 inte	grated	
Integrated Fa	mily deductible	N/A		\$9,600 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,300 / \$500 / \$0		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,600 / \$1,000 / \$0		N/A		
Individual Out-	Individual Out-of-pocket maximum		\$7,000		\$6,550	
	pocket maximum	\$14,000		\$13,100		
	-only coverage deductible	N/A		\$4,800		
HSA family pla	n: Individual deductible	N/A		\$4,800		
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	After 1st three non-preventive	40%	Х	

Family Out-of-	-of-pocket maximum pocket maximum	\$7,000 \$14,000		\$6,550 \$13,100	
	-only coverage deductible	N/A		\$4,800	
	n: Individual deductible	N/A		\$4,800	
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	After 1st three non-preventive visits	40%	х
Health care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	х
visit	Specialist visit	\$105	After 1st three non-preventive visits	40%	х
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 100%	X	40% 40%	X
1 6313	Imaging (CT/PET scans, MRIs)	100%	X	40%	X
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
condition	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	100%	X	40%	X
services	Outpatient visit	100%	X	40%	X
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х
Need	Emergency room physician fee (waived if admitted)	No charge		0%	Х
immediate	Emergency medical transportation	100%	X	40%	Х
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)	100%	Х	40%	Х
riospitai stay	Physician/surgeon fee	100%	Х	40%	Х
	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	Х
	Mental/Behavioral health other outpatient items and services	\$75	х	40%	Х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	Х
behavioral	Mental/Behavioral health inpatient physician fee	100%	х	40%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	х
	Substance Use disorder other outpatient items and services	\$75	х	40%	х
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	х
	Substance use disorder inpatient physician fee	100%	Х	40%	х
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	100%	Х	40%	Х
	services Professional	100%	Х	40%	Х
	Home health care (cost share per visit)	100%	Х	40%	Х
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$75 \$75		40%	X
recovering or other special	Skilled nursing care	100%	Х	40%	х
health needs	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge	^	0%	X
Child eye care	Eye exam	No charge		No charge	
J.III.d Gyd Gaile	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed				
Child Dental	Restorative Procedures	20%		20%	
Basic	Periodontal Maintenance Services				
Basic Services		-	-		
Services	Crowns and Casts Endodontics				
		50%		50%	
Services Child Dental Major	Endodontics Periodontics (other than maintenance)	50%		50%	

Summary of Be	anofite and	Coverage

-	hare amounts describe the Enrollee's out of pocket costs.	Catastrop	ohic Plan
	e - AV Calculator		
Plan design in	cludes a deductible?	Yes, into	egrated
	dividual deductible	\$7,350 in	ntegrated
	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	\$14,700 ii N/	
	ctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	N/ \$7,3	
Family Out-of-	pocket maximum	\$14,	
	-only coverage deductible n: Individual deductible	N/ N/	
TIOA Iailiily pia	ii. Ilidividual deductible	11/	Λ
Common		Member Cost	Deductible
Medical Event	Service Type	Share	Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits
Health care provider's office or clinic	Other practitioner office visit	0%	After 1st three non-preventive visits
visit	Specialist visit	0%	х
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	0%	X
rests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	Х
	Tier 2	0%	X
Drugs to treat illness or condition			
	Tier 3	0%	Х
	Tier 4	0%	X
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	0%	X
services	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
	Emergency room physician fee (waived if admitted)	No charge	
Need	Emergency medical transportation	0%	X
immediate attention	Urgent care	0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)	0%	×
	Physician/surgeon fee	0%	X
	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services	0%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	0%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services	0%	Х
	Substance Use inpatient facility fee (e.g. hospital room)	0%	Х
	Substance use disorder inpatient physician fee	0%	Х
	Prenatal care and preconception visits	No charge	^
Pregnancy	Delivery and all inpatient Hospital	0%	Х
og.iuiioy	services Professional	0%	X
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation services Outpatient Habilitation services	0% 0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	Х
	Oral Exam	U /0	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures	0%	X
Services	Periodontal Maintenance Services		X
	Crowns and Casts		Х
Child Dental	Endodontics Periodontics (other than maintanance)	- 00/	X
Major Services	Periodontics (other than maintenance)	0%	X
	Prosthodontics Oral Surgery		X
Child Orthodontics	Medically necessary orthodontics	0%	Х

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Date: March 14, 2017



Julillial y Oi	Benefits and Coverage					
Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Platinu Coinsurand		Platinu Copay P	
Actuarial Value	e - AV Calculator		91.2%		88.1%	
	cludes a deductible?		No		No	
	dividual deductible amily deductible		\$0 \$0		\$0 \$0	
Individual de	ductible, NOT integrated: Me		\$0 / \$0 /		\$0 / \$0 /	
	ctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$0 / \$0 / \$3,35		\$0 / \$0 / \$3,350	
Family Out-of-	pocket maximum		\$6,70		\$6,700	
	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	800	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Wedical Event	36	vice Type	Silare	Applies	Silate	Applies
	Primary care visit to treat an ir	ijury, illness, or condition	\$15		\$15	
Health care						
provider's	Other practitioner office visit		\$15		\$15	
office or clinic visit						
	Specialist visit		\$30		\$30	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
	Laboratory Tests		\$15		\$15	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$30 10%		\$30 \$75	
		,				
	Tier 1		\$5		\$5	
	Tier 2		\$15		\$15	
Drugs to treat illness or			*.*		*	
condition	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
0.1000	Surgery facility fee (e.g., ASC)		10%		\$100	
Outpatient services	Physician/surgeon fees Outpatient visit		10%		\$25 10%	
	Emergency room facility fee (v	vaived if admitted)	10% \$150		\$150	
		-				
Need	Emergency room physician fer Emergency medical transporta		No charge \$150		No charge \$150	
immediate attention	Lineigency medical transports	uion	\$150		\$150	
	Urgent care		\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		\$250 per day up to 5 days	
1103pitai stay	Physician/surgeon fee		10%		No charge	
	Mark 1/2 day is a literatura day	article and the second second	0.45		045	
	Mental/Behavioral health outp	atient office visits	\$15		\$15	
	Mental/Behavioral health othe	r outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		\$250 per day up	
Mental health,	7 7 7 7				to 5 days	
behavioral health, or	Mental/Behavioral health inpat	ient physician fee	10%		No charge	
substance	Substance Use disorder outpatient office visits		\$15		\$15	
abuse needs	Substance Use disorder outpatient office visits		Ψίδ		Ψισ	
	Substance Use disorder other	outpatient items and services	\$15		\$15	
	Substance Use inpatient facilit	v fee (e.g. hospital room)	10%		\$250 per day up	
	· ·				to 5 days	
	Substance use disorder inpati		10%		No charge	
December	Prenatal care and preconcepti		No charge		No charge \$250 per day up	
Pregnancy	Delivery and all inpatient services	Hospital Professional	10%		to 5 days	
	Home health care (cost share		10%		No charge \$20	
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		\$15 \$15		\$15 \$15	
recovering or other special	Skilled nursing care	-	10%		\$150 per day up	
health needs	Durable medical equipment		10%		to 5 days 10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge No charge		No charge No charge	
	Oral Exam		. 10 Sharge		. 10 Sharge	
Child Dental Diagnostic	Preventive - Cleaning					
and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive						
Child Dental	Restorative Procedures		Not O-		Not Com	
Basic Services	Periodontal Maintenance Serv	ices	Not Covered		Not Covered	
	Crowns and Casts Endodontics				Not Covered Not Covered	
Child Dental Major	Periodontics (other than maint	enance)	Not Covered		Not Covered Not Covered	
Services	Prosthodontics	,			Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodon	tics	Not Covered		Not Covered	
- Caontios						

Summary	of	Benefits	and	Coverage	ŕ

Date: Marc	ch 14, 2017					
Summary of	Benefits and Coverage					
Member Cost S	hare amounts describe the Er	rollee's out of pocket costs.	Gold Coinsurand		Gold Copay P	
Actuarial Value	e - AV Calculator		81.8%	6	78.4%	
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible		\$0		\$0	
	ductible, NOT integrated: M ctible, NOT integrated: Medi		\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
Individual Out-	-of-pocket maximum		\$6,00	0	\$6,000)
HSA plan: Self	pocket maximum -only coverage deductible		\$12,00 N/A	JU	\$12,00 N/A	U
HSA family pla	n: Individual deductible		N/A		N/A	
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event	Se	ervice Type	Share	Applies	Share	Applies
	Primary care visit to treat an	njury, illness, or condition	\$25		\$25	
Health care provider's office or clinic	Other practitioner office visit		\$25		\$25	
visit	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	mmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	g	\$35 \$55		\$35 \$55	
	Imaging (CT/PET scans, MRI		20%		\$275	
	Tier 1		\$15		\$15	
Drugs to treat illness or	Tier 2		\$55		\$55	
condition	Tier 3		\$75		\$75	
	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 Emergency room facility fee (waived if admitted)	20% \$325		20% \$325	
	7 1	·				
Need	Emergency room physician fee (waived if admitted) Emergency medical transportation		No charge		No charge	
immediate attention	Emergency medical iransportation		\$250		\$250	
	Urgent care		\$25		\$25	
	Facility fee (e.g. hospital roor	n)	20%		\$600 per day up	
Hospital stay	Physician/surgeon fee	<u></u>	20%		to 5 days No charge	
	Mental/Behavioral health out	patient office visits	\$25		\$25	
	Mental/Behavioral health other outpatient items and services		\$25		\$25	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inpa	atient physician fee	20%		to 5 days No charge	
behavioral health, or substance	Substance Use disorder outp	. ,	\$25		\$25	
abuse needs	Cubstance Ose disorder outp	attent office visits	Ψ20		Ψ20	
	Substance Use disorder othe	r outpatient items and services	\$25		\$25	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpat	ient physician fee	20%		No charge	
	Prenatal care and preconcep	tion visits	No charge		No charge \$600 per day up	
Pregnancy	Delivery and all inpatient services	Hospital	20%		to 5 days	
	Home health care (cost share	Professional per visit)	20%		No charge \$30	
Help	Outpatient Rehabilitation serv	rices	\$25		\$25	
recovering or other special	Outpatient Habilitation service	d5	\$25		\$25 \$300 per day up	
health needs	Skilled nursing care Durable medical equipment		20%		to 5 days 20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam	contact langer in Herry Colors	No charge		No charge	
	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth					
Diagnostic and			Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services		vices	Not Covered		Not Covered	
-0000	Periodontal Maintenance Ser Crowns and Casts	vices			Not Covered	
Child Dental	Endodontics	4	N o		Not Covered	
Major Services	Periodontics (other than mair Prosthodontics	itenance)	Not Covered		Not Covered	
	Oral Surgery				Not Covered Not Covered	
Child	Medically necessary orthodol	ntics	Not Covered		Not Covered	
Orthodontics	,				22.0.00	

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Summary of	Benefits and Coverage		Individual	l	
Member Cost S	hare amounts describe the En	ollee's out of pocket costs.	Silver Plan		
	- AV Calculator		71.9%		
	cludes a deductible?		Yes, Medical/Pha	armacy	
Integrated Inc	dividual deductible		N/A	amaoy	
	mily deductible ductible, NOT integrated: Me	edical / Pharmacy / Dental	N/A \$2,500/ \$130	/ \$0	
	tible, NOT integrated: Medic	al / Pharmacy / Dental	\$5,000/ \$260 \$7,000	/ \$0	
Family Out-of-	pocket maximum		\$14,000		
	only coverage deductible n: Individual deductible		N/A N/A		
pia			1471		
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an in	njury, illness, or condition	\$35		
Health care provider's office or clinic	Other practitioner office visit		\$35		
visit	Specialist visit		\$75		
	Preventive care/ screening/ in	nmunization	No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	,	\$35 \$75		
Tesis	Imaging (CT/PET scans, MRIs		\$300		
	Tier 1		\$15	Pharmacy deductible	
Drugs to treat	Tier 2		\$55	Pharmacy deductible	
condition	Tier 3		\$80	Pharmacy deductible	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees		20%		
services	Outpatient visit		20%		
	Emergency room facility fee (v	vaived if admitted)	\$350		
	Emergency room physician fe	No charge			
Need	Emergency medical transporta		\$250	X	
immediate attention	Urgent care		\$35		
	Facility fee (e.g. hospital room)	20%	Х	
Hospital stay	Physician/surgeon fee	,	20%	X	
	Mental/Behavioral health outp	\$35	· ·		
	Mental/Behavioral health othe	\$35			
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	
Mental health, behavioral	Mental/Behavioral health inpa	20%	Х		
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$35		
	Substance Use disorder other	\$35			
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х	
	Substance use disorder inpati		20%	Х	
	Prenatal care and preconcept		No charge		
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х	
	Home health care (cost share	Professional per visit)	20% \$45	X	
Help	Outpatient Rehabilitation serv	ices	\$35		
recovering or	Outpatient Habilitation service	S	\$35		
other special health needs	Skilled nursing care		20%	Х	
	Durable medical equipment Hospice service		20% No charge		
Child ava care	Eye exam		No charge		
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		
Child Dental	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		
Child Dental	Space Maintainers - Fixed				
Basic Services	Restorative Procedures Periodontal Maintenance Service Crowns and Casts	rices	Not Covered		
Child Dental Major	Endodontics Periodontics (other than main	enance)	Not Covered		

Medically necessary orthodontics

Not Covered

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB Silver		CCSB		
	- AV Calculator	. ,	Coinsurance 71.9%	rian	Copay Pla 71.4%	ırı
	cludes a deductible?		Yes, Medical/Ph	armacy	Yes, Medical/Ph	armacy
	dividual deductible mily deductible		N/A N/A		N/A N/A	
Individual de	ductible, NOT integrated: Me		\$2,000 / \$125		\$2,000/ \$125	
	tible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$4,000 / \$250 \$7,000	/\$0	\$4,000 / \$250 \$7,000	1/\$0
	pocket maximum -only coverage deductible		\$14,000 N/A		\$14,000 N/A	
	n: Individual deductible		N/A		N/A	
Common Medical Event	So	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Medical Event	Primary care visit to treat an ir		\$45	Applies	\$45	Applies
Health care	Other practitioner office visit		\$45		\$45	
office or clinic visit	Specialist visit		\$75		\$75	
	Preventive care/ screening/ im	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	\$40 \$70		\$40 \$70	
16313	Imaging (CT/PET scans, MRIs		20%		\$300	
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmacy deductible
Drugs to treat	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$85	Pharmacy deductible	\$85	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%		20% 20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (v	vaived if admitted)	\$350		\$350	
Need	Emergency room physician fee	e (waived if admitted)	No charge		No charge	
immediate	Emergency medical transporta	ation	\$250	X	\$250	X
attention	Urgent care		\$45		\$45	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	Х
nospital stay	Physician/surgeon fee		20%	Х	20%	Х
	Mental/Behavioral health outp	atient office visits	\$45		\$45	
	Mental/Behavioral health othe	r outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	20%	Х	20%	Х
health, or substance abuse needs	Substance Use disorder outpa		\$45		\$45	
	Substance Use disorder other	outpatient items and services	\$45		\$45	
	Substance Use inpatient facilit	<u> </u>	20%	X	20%	X
	Substance use disorder inpatie		20%	Х	20%	Х
Pregnancy	Prenatal care and preconcepti Delivery and all inpatient	On visits Hospital	No charge 20%	X	No charge 20%	Х
_g	services	Professional	20%	X	20%	X
	Home health care (cost share	per visit)	20%		\$45	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$45 \$45		\$45 \$45	
	Skilled nursing care		20%	х	20%	х
health needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge		No charge	
01.11.12	Oral Exam				·	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		1401 Covered	
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Service Crowns and Casts	ices			Not Covered	
Child Dental	Endodontics				Not Covered	
Major Services	Periodontics (other than maint	enance)	Not Covered		Not Covered	
23171363	Prosthodontics Oral Surgery		-		Not Covered Not Covered	
Child		tion.	Ne: O			
Orthodontics	Medically necessary orthodon	ucə	Not Covered		Not Covered	

-	Benefits and Coverage	colleges out of posket agets	CCSB Silver	
	hare amounts describe the En	ollee's out of pocket costs.	HDHP PI 71.7%	
	cludes a deductible? dividual deductible		Yes, integr \$2,000 integ	grated
	amily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dontal	\$4,000 integ N/A	grated
Family deduc	ctible, NOT integrated: Medic		N/A	
	-of-pocket maximum pocket maximum		\$6,550 \$13,10	
HSA plan: Self	only coverage deductible		\$2,000)
HSA family pla	n: Individual deductible		\$2,600 <u>\$2</u> ,	<u>700</u>
Common				
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	20%	х
Health care provider's office or clinic	Other practitioner office visit		20%	х
visit	Specialist visit		20%	x
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	20%	X
	Imaging (CT/PET scans, MRIs		20%	X
	Tier 1		20% up to \$250 per script	х
Drugs to treat	Tier 2		20% up to \$250 per script	х
illness or condition	Tier 3		20% up to \$250 per script	х
	Tier 4		20% up to \$250 per script	Х
	Surgery facility fee (e.g., ASC		20%	Х
Outpatient services	Physician/surgeon fees		20%	Х
	Outpatient visit		20%	X
	Emergency room facility fee (v	vaived if admitted)	20%	Х
Need	Emergency room physician fe	e (waived if admitted)	0%	Х
immediate	Emergency medical transportation		20%	Х
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
,	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits		20%	х
	Mental/Behavioral health other outpatient items and services		20%	Х
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х
health, or			2070	^
substance abuse needs	Substance Use disorder outpatient office visits		20%	Х
	Substance Use disorder other outpatient items and services		20%	Х
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpati	ent physician fee	20%	Х
	Prenatal care and preconcept	on visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
Holm	Home health care (cost share Outpatient Rehabilitation serv		20%	X
Help recovering or	Outpatient Habilitation service		20%	X
other special health needs	Skilled nursing care		20%	Х
neath needs	Durable medical equipment		20%	X
	Hospice service Eye exam		0% No charge	X
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam			
Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures		Not Covered	
Basic	Periodontal Maintenance Serv	rices		
Basic Services			The second secon	
Services	Crowns and Casts Endodontics			
	Crowns and Casts	enance)	Not Covered	
Services Child Dental	Crowns and Casts Endodontics Periodontics (other than maint Prosthodontics	enance)	Not Covered	
Services Child Dental Major	Crowns and Casts Endodontics Periodontics (other than main	enance)	Not Covered	

Summary of	Benefits and Coverage					
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL		
Actuarial Value	e - AV Calculator		93.9%		88.0%	
Plan design in	cludes a deductible?		Yes, Medical/	Pharmacy	Yes, Medical/Phar	rmacy
	dividual deductible amily deductible		N/A N/A		N/A N/A	
	ductible, NOT integrated: Me	edical / Pharmacy / Dental	\$75 / \$0		\$650 / \$50 / \$	0
	ctible, NOT integrated: Medic	al / Pharmacy / Dental	\$150 / \$0		\$1,300 / \$100 /	\$0
	-of-pocket maximum pocket maximum		\$1,00 \$2,00		\$2,450 \$4,900	
	only coverage deductible		N/A		N/A	
nsa family pia	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$5		\$10	
Health care provider's office or clinic	Other practitioner office visit		\$5		\$10	
visit	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	n	\$8 \$8		\$15 \$25	
Tesis	Imaging (CT/PET scans, MRI		\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat	Tier 2		\$10		\$20	Pharmacy deductible
illness or condition	Tier 3		\$15		\$35	Pharmacy deductible
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy	Pharmacy deductible
	Surgery facility fee (e.g., ASC	1	per script 10%		deductible 15%	deductible
Outpatient services	Physician/surgeon fees)	10%		15%	
Services	Outpatient visit		10%		15%	
	Emergency room facility fee (vaived if admitted)	\$50		\$100	
	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transport	ation	\$30	Х	\$75	Х
attention	Urgent care		\$5		\$10	
	English for (o.g. bospital room	a.	400/	X	450/	X
Hospital stay	Facility fee (e.g. hospital room	')	10%		15%	
	Physician/surgeon fee		10%	X	15%	X
	Mental/Behavioral health outp	atient office visits	\$5		\$10	
	Mental/Behavioral health othe	r outpatient items and services	\$5		\$10	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	10%	Х	15%	Х
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$5		\$10	
abase necas						
	Substance Use disorder other	outpatient items and services	\$5		\$10	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	10%	Х	15%	Х
	Substance use disorder inpati	ent physician fee	10%	х	15%	Х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	10%	Х	15%	Х
		Professional per visit)	10%	X	15% \$15	X
Halm	Home health care (cost share Outpatient Rehabilitation serv		\$3 \$5		\$15 \$10	
Help recovering or	Outpatient Habilitation service		\$5		\$10	
other special health needs	Skilled nursing care		10%	Х	15%	Х
nearm needs	Durable medical equipment		10%		15%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care		contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				-	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed					
Basic Services	Restorative Procedures	door	Not Covered		Not Covered	
	Periodontal Maintenance Service Crowns and Casts	/ICES				
Child Dental	Endodontics		-			
Major Services	Periodontics (other than main	tenance)	Not Covered		Not Covered	
- SI 1100a	Prosthodontics Oral Surgery		-			
Child						
Orthodontics	Medically necessary orthodor	tics	Not Covered		Not Covered	

	nare amounts describe the Enrollee's	out of pocket costs.	Silver Plan 200%-250% FP	L
	- AV Calculator		73.9%	
	cludes a deductible?		Yes, Medical/Pharr N/A	nacy
Integrated Fa	mily deductible		N/A	
	ductible, NOT integrated: Medical / tible, NOT integrated: Medical / Ph		\$2,200 / \$130 / \$ \$4,400 / \$260 / \$	
Individual Out-	of-pocket maximum	armacy / Dentai	\$5,850	ро
	oocket maximum only coverage deductible		\$11,700 N/A	
	n: Individual deductible		N/A	
Common Medical Event	Service T	уре	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, il	lness, or condition	\$30	
Health care provider's office or clinic	Other practitioner office visit		\$30	
visit	Specialist visit		\$75	
	Preventive care/ screening/ immuniz	ation	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$75	
10313	Imaging (CT/PET scans, MRIs)		\$300	
	Tier 1		\$15	Pharmacy
Drugs to treat	Tier 2		\$50	Pharmacy
illness or condition	Tier 3	\$75	Pharmacy	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy
	Surgery facility fee (e.g., ASC)		20%	acadolible
Outpatient services	Physician/surgeon fees		20%	
SCI VICES	Outpatient visit		20%	
	Emergency room facility fee (waived	if admitted)	\$350	
	Emergency room physician fee (waiv	red if admitted)	No charge	
Need immediate	Emergency medical transportation		\$250	Х
attention	Urgent care		\$30	
	Facility fee (e.g. hospital room)		20%	X
Hospital stay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		\$30	
	Mental/Behavioral health other outpa	atient items and services	\$30	
	Mental/Behavioral health inpatient fa	cility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient ph	nysician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpatient of	ffice visits	\$30	
	Substance Use disorder other outpa	tient items and services	\$30	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient phy	ysician fee	20%	Х
	Prenatal care and preconception visi	its	No charge	
Pregnancy	Delivery and all inpatient services Profe		20%	X
	Home health care (cost share per vis	ssional sit)	\$40	^
Help	Outpatient Rehabilitation services Outpatient Habilitation services		\$30 \$30	
recovering or other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	^
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact Oral Exam	enses in lieu of glasses)	No charge	
Child Dental Diagnostic and	Preventive - Cleaning Preventive - X-ray Scalants per Teeth		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services		Not Covered	
	Crowns and Casts			
Child Dental	Endodontics			
Maior	Periodontics (other than maintenance	e)	Not Covered	

Child Dental Major Services

Periodontics (other than maintenance)

Medically necessary orthodontics

Prosthodontics Oral Surgery

Not Covered

Not Covered

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	60.8%	61.4%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	\$4,800 integrated
Integrated Family deductible	N/A	\$9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 / \$0	N/A
Individual Out-of-pocket maximum	\$7,000	\$6,550
Family Out-of-pocket maximum	\$14,000	\$13,100
HSA plan: Self-only coverage deductible	N/A	\$4,800
HSA family plan: Individual deductible	N/A	\$4,800

	-of-pocket maximum pocket maximum	\$7,000 \$14,000		\$6,550 \$13,10	
	-only coverage deductible	N/A		\$4,800	
	n: Individual deductible	N/A		\$4,8	
Common			Deductible	Member Cost	Deductible
Medical Event	Service Type	Member Cost Share	Applies	Share	Applies
			After 1st three		
	Primary care visit to treat an injury, illness, or condition	\$75	non-preventive	40%	Х
			visits		
Health care			After 1st three		
provider's	Other practitioner office visit	\$75	non-preventive	40%	Х
office or clinic			visits		
visit			After 1st three		
	Specialist visit	\$105	non-preventive	40%	Х
	December 1997	No. 1	visits	N. I	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$40		No charge 40%	X
Tests	X-rays and Diagnostic Imaging	100%	Х	40%	X
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X
	, ,	100% up to \$500 per script		40% up to \$500	
	Tier 1	after pharmacy deductible	Pharmacy Deductible	per script	Х
				P	
_	Tier 2	100% up to \$500 per script	Pharmacy	40% up to \$500	Х
Drugs to treat	1.0. 2	after pharmacy deductible	Deductible	per script	^
illness or condition		1000/ up to \$500 per ceript	Dhaman	400/ up to \$500	
Contraction	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
		and pharmady deductible	_ 30000000	por acript	
	Tier 4	100% up to \$500 per script	Pharmacy	40% up to \$500	V
	1101 7	after pharmacy deductible	Deductible	per script	Х
	Surgery facility fee (e.g., ASC)	100%	Х	40%	Х
Outpatient	Physician/surgeon fees	100%	X	40%	Х
services	Outpatient visit	100%	Х	40%	Х
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х
		10070	^	70 /0	^
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need	Emergency medical transportation	100%	Х	40%	Х
immediate attention				1077	
attention			After 1st three		
	Urgent care	\$75	non-preventive	40%	Х
			visits		
	Facility fee (e.g. hospital room)	100%	Х	40%	Х
Hospital stay	raciity lee (e.g. nospital room)	100%	^	40%	^
	Physician/surgeon fee	100%	X	40%	X
			After 1st three		
	Mental/Behavioral health outpatient office visits	\$75	non-preventive	40%	Х
			visits		
	Mental/Behavioral health other outpatient items and services	\$75	Х	40%	Х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	Х
Mental health,	Mental/benavioral nealth inpatient facility fee (e.g.nospital room)	100%	^	40%	^
behavioral	Mental/Behavioral health inpatient physician fee	100%	Х	40%	Х
health, or			46. 4		
substance	Substance Lies disorder outpetient office visits	Ф7 <i>Е</i>	After 1st three	400/	v
abuse needs	Substance Use disorder outpatient office visits	\$75	non-preventive visits	40%	Х
			VIOLO		
	Substance Use disorder other outpatient items and services	\$75	Х	40%	Х
	Substance Use inpatient facility fee (e.g. hospital room)	100%	Х	40%	Х
	(
	Substance use disorder inpatient physician fee	100%	Х	40%	Х
	Prenatal care and preconception visits	No charge		No charge	
Danasa			,,		.,
Pregnancy	Delivery and all inpatient services Hospital	100%	Х	40%	Х
	Professional	100%	X	40%	X
	Home health care (cost share per visit)	100%	X	40%	X
Help	Outpatient Rehabilitation services	\$75		40%	X
recovering or	Outpatient Habilitation services	\$75		40%	Х
other special	Skilled nursing care	100%	Х	40%	Х
health needs	Durable medical equipment	100%	Х	40%	Х
	Hospice service	No charge		0%	Х
01.11.1	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				
Child Dental	Preventive - Cleaning	1		1	
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and	Sealants per Tooth				
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental					
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services			0076160	
	Crowns and Casts				
Child Dental	Endodontics				
Child Dental Maior		Not Covered		Not Covered	
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major	Periodontics (other than maintenance) Prosthodontics	Not Covered		Not Covered	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major	Periodontics (other than maintenance) Prosthodontics	Not Covered		Not Covered Not Covered	

2018 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: March 14, 2017

Summary o	f Benefits	and	Coverage
Julilliai y C	Denenia	anu	Coverage

	nare amounts describe the Enro	ollee's out of pocket costs.	Catastro	phic Plan
	ludes a deductible?		Yes int	egrated
Integrated Inc	lividual deductible		\$7,350 ir	ntegrated
	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental		ntegrated /A
	tible, NOT integrated: Medica of-pocket maximum	al / Pharmacy / Dental		/A 350
amily Out-of-	oocket maximum		\$14	,700
	only coverage deductible n: Individual deductible			/A /A
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	0%	After 1st three non-preventive visits
Health care provider's office or clinic	Other practitioner office visit		0%	After 1st three non-preventive visits
visit	Specialist visit		0%	Х
	Preventive care/ screening/ im	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		0% 0%	X
esis	Imaging (CT/PET scans, MRIs		0%	X
	Tier 1		0%	х
Drugs to treat	Tier 2		0%	Х
llness or condition	Tier 3		0%	Х
	Tier 4		0%	X
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		0%	X
services	Outpatient visit		0%	X
	Emergency room facility fee (w	raived if admitted)	0%	Х
Need	Emergency room physician fee (waived if admitted)		No charge	
mmediate	Emergency medical transportation		0%	X
attention	Urgent care		0%	After 1st three non-preventiv visits
	Facility fee (e.g. hospital room)		0%	X
Hospital stay	Physician/surgeon fee		0%	Х
	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventiv visits
	Mental/Behavioral health other outpatient items and services		0%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	0%	Х
nealth, or substance abuse needs	Substance Use disorder outpa	tient office visits	0%	After 1st three non-preventiv visits
	Substance Use disorder other	outpatient items and services	0%	х
	Substance Use inpatient facility fee (e.g. hospital room)		0%	Х
	Substance use disorder inpatie	· · · · · · · · · · · · · · · · · · ·	0%	х
	Prenatal care and preconception	on visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	Х
	services	Professional	0%	X
Help	Home health care (cost share Outpatient Rehabilitation service	ces	0% 0%	X
ecovering or	Outpatient Habilitation services	3	0%	X
other special nealth needs	Skilled nursing care		0%	Х
nocus	Durable medical equipment Hospice service		0% 0%	X
Shild	Eye exam		No charge	<u> </u>
Child eye care	1 pair of glasses per year (or co	ontact lenses in lieu of glasses)	0%	Х
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic and	Preventive - X-ray		Not Covered	
reventive	Sealants per Tooth Topical Fluoride Application			
Child Dental	Space Maintainers - Fixed Restorative Procedures			
Basic Bervices		ione	Not Covered	
	Periodontal Maintenance Servi Crowns and Casts	UCES		
Child Dental	Endodontics		No. C	
Major Services	Periodontics (other than mainted Prosthodontics	enance)	Not Covered	
	Oral Surgery			
Child	Medically necessary orthodont		Not Covered	

Endnotes to Covered California 2018 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 the specified deductible amount for individual coverage or \$X,XXX2,700 for Plan Year 2018. 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 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 2017 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
2	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;
	Drugs that are recommended by P&T committee based
3	on drug safety, efficacy and cost or;
	Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	Drugs that are biologics and drugs that the Food and
	Drug Administration (FDA) or drug manufacturer requires to
	be distributed through specialty pharmacies;
4	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.