### Covered California 2018 Patient-Centered Benefit Plan Designs<sup>1</sup>

Final Board-approved March 14, 2017<sup>2</sup>

<sup>&</sup>lt;sup>1</sup> These are the Standard Benefit Plan Designs pursuant to Government Code Section 100504(c).

<sup>&</sup>lt;sup>2</sup> 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



	hare amounts describe the E	nrollee's out of pocket costs.	Platinu Coinsurand	e Plan	Platinu Copay P	lan
	e - AV Calculator		91.29	6	88.1%	•
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible	ladiant ( Dhamana ( Danta)	\$0	100	\$0 \$0 / \$0 /	***
Family deduc	ductible, NOT integrated: Motible, NOT integrated: Med	ical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 /	
ndividual Out-	-of-pocket maximum pocket maximum		\$3,35	0	\$3,350	)
	-only coverage deductible		\$6,70 N/A	U	\$6,700 N/A	J
ISA family pla	n: Individual deductible		N/A		N/A	
Common			Member Cost	Deductible	Member Cost	Deductib
Medical Event	s	ervice Type	Share	Applies	Share	Applies
	Primary care visit to treat an	injury, illness, or condition	\$15		\$15	
lealth care rovider's iffice or clinic	Other practitioner office visit		\$15		\$15	
risit	Specialist visit		\$30		\$30	
	Preventive care/ screening/	mmunization	No charge		No charge	
ests	Laboratory Tests X-rays and Diagnostic Imagi		\$15		\$15	
esis	Imaging (CT/PET scans, MR		\$30 10%		\$30 \$75	
	Tier 1		\$5		\$5	
Orugs to treat	Tier 2		\$15		\$15	
Iness or condition	Tier 3		\$25		\$25	
			10% up to \$250		10% up to \$250	
	Tier 4		per script		per script	
Outpatient	Surgery facility fee (e.g., AS	C)	10%		\$100	
ervices	Physician/surgeon fees Outpatient visit		10% 10%		\$25 10%	
		(waived if admitted)	\$150		\$150	
	Emergency room facility fee	(waived ii admilled)	\$150		\$150	
leed	Emergency room physician t		No charge		No charge	
nmediate ttention	Emergency medical transpo	tation	\$150		\$150	
	Urgent care		\$15		\$15	
	Facility fee (e.g. hospital roo	m)	10%		\$250 per day up	
lospital stay	Physician/surgeon fee	<u>′</u>	10%		to 5 days No charge	
	Mental/Behavioral health ou	patient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services		\$15		\$15	
	Mental/Behavioral health inp	10%		\$250 per day up		
Mental health, ehavioral	Mental/Behavioral health inp		10%		to 5 days No charge	
ealth, or ubstance	Substance Use disorder out		045			
ibuse needs	Substance use disorder out	patient office visits	\$15		\$15	
	Substance Use disorder oth	er outpatient items and services	\$15		\$15	
	Substance Use inpatient fac	lity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpa	tient physician fee	10%		No charge	
	Prenatal care and preconce	otion visits	No charge		No charge	
regnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services	Professional	10%		No charge	
	Home health care (cost share Outpatient Rehabilitation ser	e per visit)	10% \$15		\$20 \$15	
lelp ecovering or	Outpatient Habilitation service		\$15 \$15		\$15 \$15	
ther special	Skilled nursing care		10%		\$150 per day up	
ealth needs	Durable medical equipment		10%		to 5 days 10%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
hild eye care		contact lenses in lieu of glasses)	No charge		No charge	
Wall Brown	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
nd reventive	Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental	Space Maintainers - Fixed					
Shild Dental Basic Bervices	Restorative Procedures	ndoor	20%		See 2018 Dental Copay Schedule	
11003	Periodontal Maintenance Se Crowns and Casts	rvices				
Child Dental	Endodontics				See 2018 Dental	
Major Services	Periodontics (other than mai Prosthodontics	nteriance)	50%		Copay Schedule	
	Oral Surgery					
Child	Medically necessary orthodo	ntina	50%		\$1,000	

Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Gold Coinsuran		Gold Copay F	Plan
ctuarial Value	e - AV Calculator		81.89	%	78.49	6
	cludes a deductible?		No		No	
	dividual deductible mily deductible		\$0 \$0		\$0 \$0	
	ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$0 / \$0	/\$0	\$0 / \$0	\$0
Family deduc	ctible, NOT integrated: Medic		\$0 / \$0	/\$0	\$0 / \$0 /	\$0
ndividual Out-	-of-pocket maximum pocket maximum		\$6,00 \$12,0		\$6,00 \$12,00	
ISA plan: Self	only coverage deductible		\$12,0 N/A		\$12,00 N/A	10
ISA family pla	n: Individual deductible		N/A	ı	N/A	
			1			
Common			Member Cost	Deductible	Member Cost	Deductib
Medical Event	Se	rvice Type	Share	Applies	Share	Applies
	Primary care visit to treat an ir	niury illness or condition	\$25		\$25	
	i filliary care visit to treat air ii	ijury, iiiress, or condition	φ23		φ23	
lealth care						
rovider's	Other practitioner office visit		\$25		\$25	
ffice or clinic						
ioit	Specialist visit		\$55		\$55	
	opodianot viole		400		400	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
	Laboratory Tests		\$35		\$35	
ests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$55 20%		\$55 \$275	
		,				
	Tier 1	\$15		\$15		
rugs to treat	Tier 2		\$55		\$55	
liness or	ess or					
ondition	Tier 3		\$75		\$75	
	Tier 4		20% up to \$250		20% up to \$250	
	1101 7		per script		per script	
Outpatient	Surgery facility fee (e.g., ASC		20%		\$300	
ervices	Physician/surgeon fees		20%		\$40	
	Outpatient visit		20%		20%	
	Emergency room facility fee (v	vaived if admitted)	\$325		\$325	
	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
leed mmediate	Emergency medical transporta	ation	\$250		\$250	
ittention						
	Urgent care		\$25		\$25	
	J		1		7=1	
					\$600 per day up	
lospital stay	Facility fee (e.g. hospital room	)	20%		to 5 days	
	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health outp	atient office visits	\$25		\$25	
	Mantal/Daharriaral baalth atha		\$25		\$25	
	ivienta/benavioral nealth othe	r outpatient items and services	\$25		\$25	
	Manage UP a beautioned to a state from	tient facility fee (e.g.hospital room)			\$600 per day up	
Mental health,	ivientai/benavioral nealth inpa	tient facility fee (e.g.nospital foom)	20%		to 5 days	
ehavioral	Mental/Behavioral health inpa	tient physician fee	20%		No charge	
nealth, or						
substance sbuse needs	Substance Use disorder outpa	atient office visits	\$25		\$25	
	Substance Use disorder other	outpatient items and services	\$25		\$25	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%		\$600 per day up	
					to 5 days	
	Substance use disorder inpati		20%		No charge	
	Prenatal care and preconcept	ion visits	No charge		No charge	
regnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up to 5 days	
	services	Professional	20%		No charge	
	Home health care (cost share	per visit)	20%		\$30	
lelp .	Outpatient Rehabilitation servi Outpatient Habilitation service		\$25 \$25		\$25 \$25	
ecovering or other special	Skilled nursing care		20%		\$300 per day up	
ealth needs	-				to 5 days	
	Durable medical equipment Hospice service		20% No charge		20% No charge	
	Eye exam		No charge		No charge	
hild eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
Child Dental	Preventive - Cleaning		4			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge		No charge	
reventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures		200/		See 2018 Dental	
Basic Bervices	Periodontal Maintenance Serv	ricas	20%		Copay Schedule	
	Crowns and Casts	1003				
Child Dental	Endodontics				L	
Major	Periodontics (other than maint	enance)	50%		See 2018 Dental Copay Schedule	
Services	Prosthodontics				Copay Scriedule	
	Oral Surgery					
Child	Medically necessary orthodon	tins	50%		\$1,000	
Orthodontics	iouny nooossary oraiouon		JU /0		Ψ1,000	

viember Cost S	Benefits and Coverage	allania aut of control or	Individual	
	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plar	1
Actuarial Value	e - AV Calculator		71.9%	
	cludes a deductible?		Yes, Medical/Pha	armacy
Integrated Fa	dividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: Me ctible, NOT integrated: Medic	dical / Pharmacy / Dental	\$2,500 / \$130 \$5,000 / \$260	
ndividual Out-	-of-pocket maximum	ar / r narmacy / Demai	\$7,000	7 40
	pocket maximum -only coverage deductible		\$14,000 N/A	
	n: Individual deductible		N/A	
Common Medical Event	Ser	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	ijury, illness, or condition	\$35	
Health care provider's office or clinic	Other practitioner office visit		\$35	
visit	Specialist visit		\$75	
	Preventive care/ screening/ im	nmunization	No charge	
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	1	\$35 \$75	
. 00.0	Imaging (CT/PET scans, MRIs		\$300	
	Tier 1		\$15	Pharmac deductible
Orugs to treat	Tier 2		\$55	Pharmac
illness or condition	Tier 3		\$80	Pharmacy
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy
			deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (w	vaived if admitted)	\$350	
	Emergency room physician fee	e (waived if admitted)	No charge	
Need mmediate	Emergency medical transporta	ition	\$250	Х
attention	Urgent care		\$35	
Hospital stay	Facility fee (e.g. hospital room	)	20%	Х
Toophan olay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpa	atient office visits	\$35	
	Mental/Behavioral health other	r outpatient items and services	\$35	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	tient physician fee	20%	×
health, or	Wertan Deriavioral Treatti Inpat	ion physician rec	2070	
substance abuse needs	Substance Use disorder outpa	itient office visits	\$35	
	Substance Use disorder other	outpatient items and services	\$35	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatie	ent physician fee	20%	Х
	Prenatal care and preconcepti	on visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	Х
	Home health care (cost share Outpatient Rehabilitation servi		\$45 \$35	
Help 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 c	ontact lenses in lieu of glasses)	No charge	
	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and	Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
	Restorative Procedures			
		iono	20%	
Basic	Periodontal Maintenance Serv	ices		
Basic	Crowns and Casts			
Child Dental Basic Services Child Dental	Crowns and Casts Endodontics			
Basic Services Child Dental Major	Crowns and Casts	enance)	50%	
Basic Services Child Dental	Crowns and Casts Endodontics	enance)	50%	

Summary of	Benefits and Coverage	•				
Member Cost S	hare amounts describe the Er	nrollee's out of pocket costs.		Plan		n
Actuarial Value	e - AV Calculator		71.9%		71.4%	
				armacy		armacy
Integrated Fa	mily deductible		N/A		N/A	
Individual de	ductible, NOT integrated: M					
Individual Out-	of-pocket maximum	cai / Filai illacy / Delitai	\$7,000	7 90	\$7,000	7 40
			N/A		N/A	
Common Medical Event	S	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	injury, illness, or condition	\$45		\$45	
Health care provider's office or clinic	Other practitioner office visit		\$45		\$45	
visit	Specialist visit		\$75		\$75	
		mmunization	No charge		No charge	
Γests		200				
16515			20%		\$300	
	Tior 1		£45	Pharmacy	£45	Pharmac
				deductible	· ·	deductible
Drugs to treat	Tier 2		\$55	deductible	\$55	deductible
condition	Tier 3		\$85 20% up to \$250 per	deductible	\$85	Pharmac
	Tier 4		script after pharmacy deductible	Pharmacy deductible	script after pharmacy deductible	Pharmac
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	·)	20%		20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee	(waived if admitted)	\$350		\$350	
	Emergency room physician fo	ee (waived if admitted)	No charge		No charge	
Need	selection includes a deductable of the process of t	Х				
mmediate attention			-		7200	
	Urgent care		\$45		\$45	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%		20%	Х
	Physician/surgeon fee		20%	X	20%	Х
	Mental/Behavioral health out	patient office visits	\$45		\$45	
	Mental/Behavioral health oth	er outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health,						Х
behavioral health, or substance abuse needs				^		^
	Substance Use disorder other	er outpatient items and services	\$45		\$45	
						X
				^		Х
Prognance:				V		V
Pregnancy						X
		e per visit)		X		Х
lelp	Outpatient Rehabilitation ser	vices	\$45		\$45	
ecovering or		es				
other special nealth needs			***	Х		Х
a/ necus						
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental						
Diagnostic and			No charge		No charge	
Preventive	Topical Fluoride Application		-			
Child Dental Basic			20%			
Services		vices			ocneaule	
			-			
			-		See 2018 Dental Conav	
	Periodontics (other than main	ntenance)	50%			
Child Dental Major Services		ntenance)	50%			
Major	Prosthodontics	ntenance)	50%			

Summary of	Benefits and Coverage		CCSE	
Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver HDHP P	lan
	e - AV Calculator		71.7%	
	cludes a deductible? dividual deductible		Yes, integr \$2,000 integr	
Integrated Fa	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$4,000 integ N/A	grated
Family deduc	ctible, NOT integrated: Medic	al / Pharmacy / Dental	N/A \$6,550	<b>\</b>
Family Out-of-	pocket maximum		\$13,10	0
	only coverage deductible n: Individual deductible		\$2,000 \$2,600	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	20%	х
Health care provider's office or clinic visit	Other practitioner office visit		20%	Х
Visit	Specialist visit		20%	х
	Preventive care/ screening/ im Laboratory Tests	munization	No charge 20%	X
Tests	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs	)	20%	Х
	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) Physician/surgeon fees		20% 20%	X
services	Outpatient visit		20%	X
	Emergency room facility fee (w	raived if admitted)	20%	х
Manual	Emergency room physician fee	(waived if admitted)	0%	х
immediate	Emergency medical transporta	tion	20%	Х
Need immediate attention Hospital stay	Urgent care		20%	х
	Facility fee (e.g. hospital room)		20%	×
Hospital 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 inpat	ient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	20%	×
health, or	montal Bonavioral noditi input	on physician too	2070	
substance abuse needs	Substance Use disorder outpa	tient office visits	20%	Х
	Substance Use disorder other	outpatient items and services	20%	х
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatie	ent physician fee	20%	х
	Prenatal care and preconcepti	* *	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	Х
H-In	Home health care (cost share Outpatient Rehabilitation servi		20% 20%	X
Help recovering or	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	i pail of glasses per year (or o	ontact 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		3-	
Child Dental	Space Maintainers - Fixed			
Basic	Restorative Procedures		20%	
Services	Periodontal Maintenance Serv Crowns and Casts	ices		
Child Dental	Endodontics			
Major	Periodontics (other than maint	enance)	50%	
Services	Prosthodontics Oral Surgery			
Child		ina	E00/	
Orthodontics	Medically necessary orthodon		50%	

	hare amounts describe the Enrollee's out of pocket costs.	Silver F 100%-150 93.99	% FPL	Silver Plan 150%-200% F 88.0%	
Plan design inc	cludes a deductible?	Yes, Medical/		Yes, Medical/Pha	rmacy
Integrated Inc	dividual deductible	N/A		N/A	
Individual de	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$75 / \$0		N/A \$650 / \$50 / \$	\$0
	tible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$150 / \$0 \$1,00		\$1,300 / \$100 / \$2,450	\$0
amily Out-of-	oocket maximum	\$2,00		\$4,900	
	only coverage deductible n: Individual deductible	N/A N/A		N/A N/A	
lost running plu		107		1071	
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		\$10	
Health care provider's office or clinic visit	Other practitioner office visit	\$5		\$10	
	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$8		No charge \$15	
ests	X-rays and Diagnostic Imaging	\$8		\$25	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Orugs to treat	Tier 2	\$10		\$20	Pharmacy
condition	Tier 3	\$15		\$35	Pharmacy deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmac
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	10% 10%		15% 15%	
services	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$100	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed	Emergency medical transportation	\$30	X	\$75	Х
ttention	Urgent care	\$5		\$10	
lospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X
	Physician/surgeon fee	10%	X	15%	Х
	Mental/Behavioral health outpatient office visits	\$5		\$10	
	Mental/Behavioral health other outpatient items and services	\$5		\$10	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	10%	х	15%	Х
nealth, or	Substance Use disorder outpatient office visits	\$5		\$10	
	Substance Use disorder other outpatient items and services	\$5		\$10	
	Substance Use inpatient facility fee (e.g. hospital room)	10%	Х	15%	Х
	Substance use disorder inpatient physician fee	10%	х	15%	Х
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient Hospital	10%	Х	15%	х
	services Professional	10%	Х	15%	Х
	Home health care (cost share per visit) Outpatient Rehabilitation services	\$3		\$15	
Help	Outpatient Renabilitation services Outpatient Habilitation services	\$5 \$5		\$10 \$10	
ecovering or other special	Skilled nursing care	10%	Х	15%	х
soulth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge No charge	
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge No charge		No charge	
	Oral Exam	140 charge		140 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				
Basic	Restorative Procedures	20%		20%	
	Periodontal Maintenance Services				
	Crowns and Casts Endodontics	-			
Uniid Dentai	Periodontics (other than maintenance)	50%		50%	
Major		11.15		1	
	Prosthodontics				
wajor Services	Prosthodontics Oral Surgery				

Summary	of Ren	ofite ar	nd Cover	ane

	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan 200%-250% FP	'L
	e - AV Calculator		73.9%	
Integrated Inc	cludes a deductible? dividual deductible		Yes, Medical/Phari N/A	пасу
Integrated Fa	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	N/A \$2,200 / \$130 / \$	\$0
Family deduc	tible, NOT integrated: Medic	al / Pharmacy / Dental	\$4,400 / \$260 / \$	
	-of-pocket maximum pocket maximum		\$5,850 \$11,700	
ISA plan: Self-	only coverage deductible		N/A	
HSA family pla	n: Individual deductible		N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$30	
Health care provider's office or clinic	Other practitioner office visit		\$30	
/isit	Specialist visit		\$75	
	Preventive care/ screening/ im	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	\$35 \$75	
00.0	Imaging (CT/PET scans, MRIs		\$300	
	Tier 1		\$15	Pharmacy deductible
Orugs to treat	Tier 2		\$50	Pharmacy
llness or condition	Tier 3		\$75	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy
Outpatient	Surgery facility fee (e.g., ASC)		20%	
services	Physician/surgeon fees Outpatient visit		20% 20%	
	Emergency room facility fee (v	vaived if admitted)	\$350	
Need	Emergency room physician fee		No charge	
mmediate attention	Emergency medical transporta	ition	\$250	Х
ittention	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital room	)	20%	х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpo	atient office visits	\$30	
	Mental/Behavioral health other	r outpatient items and services	\$30	
Mental health,	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х
oehavioral	Mental/Behavioral health inpat	ient physician fee	20%	х
nealth, or substance abuse needs	Substance Use disorder outpa	tient office visits	\$30	
	Substance Use disorder other	outpatient items and services	\$30	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatie		20%	Х
	Prenatal care and preconcepti		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care (cost share	per visit)	\$40	
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		\$30 \$30	
ecovering or other special	Skilled nursing care		20%	х
nealth needs	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	L pair of glasses per year (er e	ontant langua in liqui of -t	No charge	
	1 pair of glasses per year (or c Oral Exam	ornact renses in lieu or grasses)	No charge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application			
Obild Desired	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		20%	
Services	Periodontal Maintenance Serv	ices		
	Crowns and Casts Endodontics			
Child Dental Major	Periodontics (other than maint	enance)	50%	
Services	Prosthodontics		5570	
	Oral Surgery			
Child Orthodontics	Medically necessary orthodon	tics	50%	

	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	Bronz HDHP P	lan
	e - AV Calculator	60.8%		61.49	
	cludes a deductible? dividual deductible	Yes, Medical/Pha N/A	irmacy	Yes, integ \$4,800 inte	
Integrated Fa	mily deductible	N/A	(00	\$9,600 inte	
	ductible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 \$12,600 / \$1,00		N/A N/A	
ndividual Out-	-of-pocket maximum	\$7,000		\$6,55	
	pocket maximum -only coverage deductible	\$14,000 N/A		\$13,10 \$4,80	
	n: Individual deductible	N/A		\$4,80	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
medicai Event	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	
	Laboratory Tests	\$40	, ,	40%	X
	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	100%	X	40% 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
illness or 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
	Surgery facility fee (e.g., ASC)	100%	X	40%	X
Outpatient services	Physician/surgeon fees	100%	X	40%	Х
	Outpatient visit	100%	X	40%	X
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х
Nand	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need 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%	×	40%	Х
	Physician/surgeon fee	100%	X	40%	X
	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
Mental health,		4000/	V	400/	
behavioral health, or	Mental/Behavioral health inpatient physician fee	100%	Х	40%	Х
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%	Х	40%	Х
	Substance use disorder inpatient physician fee	100%	Х	40%	X
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient Hospital	100%	Х	40%	Х
	services Professional	100%	X	40%	X
	Home health care (cost share per visit) Outpatient Rehabilitation services	100% \$75	Х	40% 40%	X
Help recovering or	Outpatient Renabilitation services  Outpatient Habilitation services	\$75 \$75		40%	X
other special	Skilled nursing care	100%	Х	40%	Х
hoolth noode	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge		0% No shares	X
Child ave save	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning	]			
	Preventive - X-ray Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services	2070		2370	
	Crowns and Casts				
Child Dental	Endodontics  Periodontics (other than maintenance)	F00/		500/	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics Oral Surgery	<u> </u>			
Child	Medically necessary orthodontics	50%		50%	

	hare amounts describe the En  - AV Calculator	once s out or pocket costs.	Catastro	orac rian
			V	oarota d
Plan design in	cludes a deductible? dividual deductible		Yes, int \$7,350 ir	egrated tegrated
Integrated Fa	mily deductible			ntegrated
Individual de	ductible, NOT integrated: Me		N.	/A
	ctible, NOT integrated: Medic -of-pocket maximum	ai / Pharmacy / Dental	\$7,:	
	-ot-pocket maximum pocket maximum		\$14	
HSA plan: Self	only coverage deductible		N.	/A
HSA family pla	n: Individual deductible		N,	/A
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, 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/ in	nmunization	No charge	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imagin		0%	X
	Imaging (CT/PET scans, MRI	s)	0%	Х
	Tier 1		0%	Х
Drugs to treat	Tier 2		0%	х
condition	Tier 3		0%	х
	Tier 4		0%	х
Outpatient	Surgery facility fee (e.g., ASC		0%	Х
outpatient services	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
	Emergency room facility fee (	vaived if admitted)	0%	Х
	Emergency room physician fe	e (waived if admitted)	No charge	
Need	Emergency medical transport		0%	Х
mmediate attention	Urgent care	21011	0%	After 1st three non-preventive
		,		visits
Hospital stay	Facility fee (e.g. hospital room	9	0%	Х
	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other	r outpatient items and services	0%	х
Mental health,	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	0%	Х
behavioral	Mental/Behavioral health inpa	tient physician fee	0%	Х
health, or substance abuse needs	Substance Use disorder outpo	atient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other	outpatient items and services	0%	х
	Substance Use inpatient facili	ty fee (e.g. hospital room)	0%	Х
	Substance use disorder inner	ent physician fee	00/	~
	Substance use disorder inpat		0%	Х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Prenatal care and preconcept Delivery and all inpatient			X
Pregnancy	Prenatal care and preconcept Delivery and all inpatient services	ion visits Hospital Professional	No charge 0% 0%	X X
Pregnancy	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share	ion visits Hospital Professional per visit)	0% 0% 0%	X X X
Help	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv	ion visits  Hospital  Professional  per visit) ices	No charge 0% 0%	X X
Help recovering or	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation service) Outpatient Habilitation service	ion visits  Hospital  Professional  per visit) ices	No charge 0% 0% 0% 0% 0%	X X X X
Help recovering or other special	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care	ion visits  Hospital  Professional  per visit) ices	No charge 0% 0% 0% 0% 0% 0% 0% 0%	X X X X X
Help recovering or other special	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment	ion visits  Hospital  Professional  per visit) ices	No charge 0% 0% 0% 0% 0%	X X X X
Help recovering or other special health needs	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care	ion visits  Hospital  Professional  per visit) ices	No charge 0% 0% 0% 0% 0% 0% 0% 0% 0%	X X X X X
Help recovering or other special health needs	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service	Hospital Professional per visit) ices	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%	X X X X X
Help recovering or other special health needs Child eye care	Prenatal care and preconcept Delivery and all inpatient services Health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Haspice service Eye exam	Hospital Professional per visit) ices	No charge  0%  0%  0%  0%  0%  0%  0%  0%  No charge	X X X X X X
Help recovering or other special health needs Child eye care	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation servi Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Coral Exam Preventive - Cleaning	Hospital Professional per visit) ices	No charge  0%  0%  0%  0%  0%  0%  0%  0%  No charge	X X X X X X
Help recovering or other special health needs Child eye care Child Dental Diagnostic	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray	Hospital Professional per visit) ices	No charge  0%  0%  0%  0%  0%  0%  0%  0%  No charge	X X X X X X
Help recovering or recovering or recovering or recovering realth needs Child eye care Child Dental Diagnostic and	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	Hospital Professional per visit) ices	No charge 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	X X X X X X
Help recovering or recovering or other special health needs  Child eye care  Child Dental Diagnostic and	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - X-ray Sealants per Tooth	Hospital Professional per visit) ices	No charge 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	X X X X X X
Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of or of the cost of the co	Hospital Professional per visit) ices	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%  No charge	X X X X X X X
Help recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	ion visits Hospital Professional Per visit) tes s	No charge 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0%	X
Help recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen	ion visits Hospital Professional Per visit) tes s	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%  No charge	X X X X X X X X
Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Sasic Services	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	ion visits Hospital Professional Per visit) tes s	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%  No charge	X X X X X X X X X X X X X X X X X X X
Help ecovering or other special nealth needs  Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services  Child Dental	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts Endodontics	ion visits Hospital Professional Professional per visit) Ices S  Contact lenses in lieu of glasses)	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%  No charge  0%	X X X X X X X X X X X X X X X X X X X
Help recovering or wher special nealth needs  Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services  Child Dental Major	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation servi Outpatient Habilitation Outpatient Habilit	ion visits Hospital Professional Professional per visit) Ices S  Contact lenses in lieu of glasses)	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%  No charge	X X X X X X X X X X X X X X X X X X X
Pregnancy  Help recovering or other special health needs  Child Dental Diagnostic and Preventive Child Dental Basic Services  Child Dental Major Services	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation serv Outpatient Hehabilitation serv Outpatient Hehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Neray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Ser Crowns and Casts Endodontics Periodontics (other than main Prosthodontics	ion visits Hospital Professional Professional per visit) Ices S  Contact lenses in lieu of glasses)	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%  No charge  0%	X X X X X X X X X X X X X X X X X X X
Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major	Prenatal care and preconcept Delivery and all inpatient services Home health care (cost share Outpatient Rehabilitation servi Outpatient Habilitation Outpatient Habilit	ion visits Hospital Professional Per visit) ices s contact lenses in lieu of glasses)	No charge  0%  0%  0%  0%  0%  0%  0%  0%  0%  No charge  0%	X



	hare amounts describe the Enr	ollee's out of pocket costs.	Platinu Coinsurance	e Plan	Platinu Copay F	Plan
	e - AV Calculator		91.29	6	88.19	b
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible	Earl (Dhamana (Daniel	\$0	1.00	\$0	1.00
Family deduc	ductible, NOT integrated: Me ctible, NOT integrated: Medic	al / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	\$0
ndividual Out-	-of-pocket maximum		\$3,35	0	\$3,35	0
	pocket maximum -only coverage deductible		\$6,70 N/A	0	\$6,70 N/A	U
	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an ir		\$15		\$15	
lealth care provider's office or clinic	Other practitioner office visit		\$15		\$15	
risit	Specialist visit		\$30		\$30	
	Preventive care/ screening/ in	munization	No charge		No charge	
ests	Laboratory Tests  X-rays and Diagnostic Imaging	1	\$15 \$30		\$15 \$30	
esis	Imaging (CT/PET scans, MRIs		10%		\$75	
	Tier 1		\$5		\$5	
ness or ondition	Tier 2		\$15		\$15	
	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)		10%		\$100	
ervices	Physician/surgeon fees		10%		\$25	
	Outpatient visit  Emergency room facility fee (v	unived if admitted)	10%		10%	
	Emergency room facility fee (v	valved if admitted)	\$150		\$150	
leed	Emergency room physician fe		No charge		No charge	
nmediate	Emergency medical transportation		\$150		\$150	
ttention	Urgent care		\$15		\$15	
	Facility fee (e.g. hospital room	)	10%		\$250 per day up	
lospital stay		)	10%		to 5 days	
	Physician/surgeon fee		10%		No charge	
	Mental/Behavioral health outpatient office visits		\$15		\$15	
	Mental/Behavioral health other outpatient items and services		\$15		\$15	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	10%		\$250 per day up	
Mental health,					to 5 days	
ehavioral nealth, or	Mental/Behavioral health inpat	ient physician fee	10%		No charge	
substance abuse needs	Substance Use disorder outpa	itient office visits	\$15		\$15	
	Substance Use disorder other	outpatient items and services	\$15		\$15	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpati	ent physician fee	10%		No charge	
	Prenatal care and preconcepti		No charge		No charge	
Pregnancy		Hospital	10%		\$250 per day up	
	Delivery and all indatient				to 5 days	
rogriditoy	Delivery and all inpatient services	Professional			No charge	
regilatioy	services  Home health care (cost share	per visit)	10% 10%		No charge \$20	
lelp	services  Home health care (cost share  Outpatient Rehabilitation servi	per visit)	10% 10% \$15		\$20 \$15	
lelp ecovering or	services  Home health care (cost share Outpatient Rehabilitation service Outpatient Habilitation service	per visit)	10% 10% \$15 \$15		\$20	
lelp ecovering or other special	services  Home health care (cost share Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care	per visit)	10% 10% \$15 \$15 10%		\$20 \$15 \$15 \$150 per day up to 5 days	
lelp ecovering or ther special	services  Home health care (cost share Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care Durable medical equipment	per visit)	10% 10% \$15 \$15 10%		\$20 \$15 \$15 \$150 per day up to 5 days 10%	
lelp ecovering or ther special lealth needs	services  Home health care (cost share Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care	per visit)	10% 10% \$15 \$15 10%		\$20 \$15 \$15 \$150 per day up to 5 days	
lelp ecovering or ther special lealth needs	services  Home health care (cost share Outpatient Rehabilitation servi Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service	per visit) ces s	10% 10% \$15 \$15 10% 10% No charge		\$20 \$15 \$15 \$150 per day up to 5 days 10% No charge	
delp ecovering or other special lealth needs Child eye care	services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or o Oral Exam	per visit) ces s	10% 10% \$15 \$15 10% No charge		\$20 \$15 \$15 \$150 per day up to 5 days 10% No charge No charge	
Help ecovering or other special leealth needs Child eye care	services  Home health care (cost share Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning	per visit) ces s	10% 10% \$15 \$15 10% 10% No charge No charge		\$20 \$15 \$15 \$15 per day up to 5 days 10% No charge No charge	
delp ecovering or ecovering or ecovering or ealth needs child eye care child Dental Diagnostic and	services  Home health care (cost share  Outpatient Rehabilitation service  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or c  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth	per visit) ces s	10% 10% \$15 \$15 10% No charge		\$20 \$15 \$15 \$150 per day up to 5 days 10% No charge No charge	
delp ecovering or ecovering or ecovering or ealth needs child eye care child Dental Diagnostic and	services  Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - V-ray Sealants per Tooth Topical Fluoride Application	per visit) ces s	10% 10% \$15 \$15 10% 10% No charge No charge		\$20 \$15 \$15 \$15 per day up to 5 days 10% No charge No charge	
delp ecovering or other special health needs Child eye care Child Dental Diagnostic and Preventive	services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoried Application Space Maintainers - Fixed	per visit) ces s	10% 10% \$15 \$15 10% 10% No charge No charge		\$20 \$15 \$15 \$15 per day up to 5 days 10% No charge No charge	
Help ecovering or other special lealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental	services  Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - V-ray Sealants per Tooth Topical Fluoride Application	per visit) ces s	10% 10% \$15 \$15 10% 10% No charge No charge		\$20 \$15 \$15 \$15 per day up to 5 days 10% No charge No charge	
delp ecovering or other special lealth needs Child eye care Child Dental Diagnostic and Preventive Child Dental Dasic	services  Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Serv	per visit) ces s s ontact lenses in lieu of glasses)	10% 10% \$15 \$15 \$15 10% 10% No charge No charge No charge		\$20 \$15 \$15 \$15 \$150 per day up to 5 days 10% No charge No charge No charge No tharge	
Help ecovering or where special health needs Child eye care Child Dental hagnostic and Preventive Child Dental hasic hasic hard dental hasic hard dental hasic hard dental hasic	services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Restorative Procedures Periodontal Maintenance Serv Crowns and Casts	per visit) ces s s ontact lenses in lieu of glasses)	10% 10% \$15 \$15 \$15 10% 10% No charge No charge No charge		\$20 \$15 \$15 \$150 per day up to 5 days 10% No charge No charge No charge Not Covered	
Help ecovering or wher special health needs Child oper care Child Dental Diagnostic oreventive Child Dental Sasic Services	services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Servictowns and Casts Endodontics	per visit) ces s ontact lenses in lieu of glasses)	10% 10% \$15 \$15 \$15 10% No charge No charge No charge Not Covered		\$20 \$15 \$15 \$15 \$15 Provided by the control of the	
Help ecovering or wher special lealth needs Child eye care Child Dental Jagnostic and Preventive Child Dental Jasic Evervices	services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Serv Crowns and Casis Endodontics Periodontics (other than maint	per visit) ces s ontact lenses in lieu of glasses)	10% 10% \$15 \$15 \$15 10% 10% No charge No charge No charge		\$20 \$15 \$15 \$15 \$15 \$15 \$150 per day up to 5 days 10% No charge No charge No charge No charge Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered	
Help ecovering or wher special lealth needs  Child eye care Child Dental Diagnostic and Preventive Child Dental Sasic Services  Child Dental Sasic Services	services Home health care (cost share Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Servictowns and Casts Endodontics	per visit) ces s ontact lenses in lieu of glasses)	10% 10% \$15 \$15 \$15 10% No charge No charge No charge Not Covered		\$20 \$15 \$15 \$15 \$15 Provided by the control of the	

	hare amounts describe the E	nrollee's out of pocket costs.	Coinsuran	ce Plan	Gold Copay Plan	
	e - AV Calculator		81.89	6	78.4%	·
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	amily deductible		\$0		\$0	
Individual de	ductible, NOT integrated: Notible, NOT integrated: Med	ledical / Pharmacy / Dental	\$0 / \$0 . \$0 / \$0 .		\$0 / \$0 / \$0 / \$0 /	
ndividual Out-	of-pocket maximum	our, mamay, zoma	\$6,00	0	\$6,000	)
	pocket maximum -only coverage deductible		\$12,00 N/A	00	\$12,00 N/A	10
	n: Individual deductible		N/A		N/A	
			1			
Common Medical Event		ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appli
		crvice Type	Ondro	прриос	Ondro	7.00
	Primary care visit to treat an	injury, illness, or condition	\$25		\$25	
lealth care						
orovider's office or clinic	Other practitioner office visit		\$25		\$25	
risit						
	Specialist visit		\$55		\$55	
	Preventive care/ screening/	immunization	No charge		No charge	
ests	Laboratory Tests X-rays and Diagnostic Imagi	200	\$35 \$55		\$35 \$55	_
esis	Imaging (CT/PET scans, MR		20%		\$275	
	Tier 1		\$15		\$15	
Orugs to treat	Tier 2		\$55		\$55	
Ilness or condition	Tier 3		\$75		\$75	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
)utpotient	Surgery facility fee (e.g., AS	C)	20%		\$300	
Outpatient ervices	Physician/surgeon fees		20%		\$40	
	Outpatient visit		20%		20%	_
	Emergency room facility fee	(waived if admitted)	\$325		\$325	
	Emergency room physician f	ee (waived if admitted)	No charge		No charge	
leed nmediate	Emergency medical transpor	tation	\$250		\$250	
ttention			1.			
	Urgent care		\$25		\$25	
	Facility fee (e.g. hospital roo	m)	20%		\$600 per day up	
lospital stay	Physician/surgeon fee	,	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 inp	atient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
Mental health, ehavioral	Mental/Behavioral health inp	atient physician fee	20%		No charge	
nealth, or					110 0110190	
ubstance buse needs	Substance Use disorder out	patient office visits	\$25		\$25	
	Substance Use disorder other	er outpatient items and services	\$25		\$25	
	Substance Use inpatient fac	lity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpa	tient physician fee	20%		No charge	
	Prenatal care and preconce		No charge		No charge	_
regnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
.gy	services	Professional	20%		to 5 days No charge	-
	Home health care (cost shar	e per visit)	20%		\$30	
lelp	Outpatient Rehabilitation ser	vices	\$25		\$25	
ecovering or	Outpatient Habilitation service	65	\$25		\$25 \$300 per day up	
ther special ealth needs	Skilled nursing care		20%		to 5 days 20%	
	Durable medical equipment Hospice service		No charge		No charge	
hild eye care	Eye exam		No charge		No charge	
,0 0010	i pail of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
hild Dental	Oral Exam Preventive - Cleaning					
iagnostic	Preventive - X-ray		Not Covered		Not Covered	
nd reventive	Sealants per Tooth Topical Fluoride Application					
hild Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures		Not Covered		Not Covered	
ervices	Periodontal Maintenance Se	rvices				
Wallet Brown	Crowns and Casts Endodontics		-		Not Covered Not Covered	
Child Dental Major	Periodontics (other than mai	ntenance)	Not Covered		Not Covered	
ervices	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child	Medically necessary orthodo		Not Covered		Not Covered	

Actuarial Value - AV Calculator  Plan design includes a deductible? Integrated Individual deductible Integrated Institute of Integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental Individual deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Individual Out-of-pocket maximum Individual Out-of-pocket maximum Individual deductible Individual Out-of-pocket maximum Individual deductible Individual Individual deductible Individual Individual deductible Individual Individual deductible Individual Individual Individual deductible Individual Indiv	-	Benefits and Coverage hare amounts describe the En	rollee's out of pocket costs.	Silver Plan		
Personate individual deductable (NE No. 1) Integrated family deductable (NE Integrated (Nedical / Pharmacy / Dental Scious 200 / 200						
Integrated Individual deductible Individual					armacy	
Individual actuations, NOT integrated, Medical Pharmacy / Dental \$2,000 (200) 300 / 500 /	Integrated Inc	dividual deductible		N/A	imacy	
Family deductible, NOT integrated: Medical Pharmacy / Dental Sci.000 5200 / 50 / 50 / 50 / 50 / 50 / 50 /	Individual de	ductible, NOT integrated: Me	edical / Pharmacy / Dental		/\$0	
Facility Director Inscription  Services Type  Member Cost Share  Primary care visit to treat an injury, illness, or condition  Services Type  Member Cost Share  Primary care visit to treat an injury, illness, or condition  Services Type  Primary care visit to treat an injury, illness, or condition  Services Type  Primary care visit to treat an injury, illness, or condition  Services Type  Proventive care/ screening/ immunization  Declarate Specialist visit  Specialist visit  Specialist visit  Specialist visit  Fests  Laboratory Yealts  Fest 1  Fest 2  Laboratory Yealts  Fest 2  Laboratory Yealts  Fer 2  Laboratory Healts  Fer 3  Services Type  Pharmatic Control of the visit of the condition of	Family deduc	tible, NOT integrated: Medic	cal / Pharmacy / Dental		/\$0	
Common Medical Event Service Type Member Cost Share Primary care visit to treat an injury, illness, or condition \$35    Primary care visit to treat an injury, illness, or condition \$35    Primary care visit to treat an injury, illness, or condition \$35    Proventive care of the primary care visit to treat an injury, illness, or condition \$35    Proventive care furcering immunication   \$35    Proventive care furcering immunication   \$35    Proventive care furcering immunication   \$55    Proventive care furcering immunication   \$50    Proventive care fur	Family Out-of-	pocket maximum		\$14,000		
Primary care visit to treat an injury, liness, or condition   \$35						
Primary care visit to treat an injury, illness, or condition   \$35   \$						
Primary care visit to treat an injury, illness, or condition   \$35		Se	rvice Type	Member Cost Share	Deductible Applies	
preventive active set of the practitioner office visit (visit visit preventive care) screening/immunization (No charge preventive care) screening of the processional protein (No charge preventive care) screening of the processional protein (No charge preventive care) screening of the processional protein (No charge preventive care) screening of the processional protein (No charge preventive care) screening of the processional protein (No charge preventive care) screening of the processional protein (No charge preventive care) screening of the processional protein (No charge preventive care) screening protein (N		Primary care visit to treat an i	njury, illness, or condition	\$35		
Specialist visit  Preventive carel screening/ immunization  Preventive carel screening/ immunization  Laboratory Tests  Arry and Diagnostic Imaging	provider's	Other practitioner office visit		\$35		
Laboratory Pests  Laboratory Pests  Laboratory Pests  Laboratory Pests  Trer 1  Ter 1  Ter 1  Ter 1  Ter 1  Ter 2  \$55  Pharm deduct  Ter 3  \$80  Pharm deduct  Ter 3  \$80  Pharm deduct  Ter 3  \$80  Pharm deduct  Ter 4  20% up to \$250 per script after pharmacy deduct  deductible  Suggery facility fee (e.g., ASC) Physician/surgeon fees  Outpalient visit  Emergency room Eacility fee (waived if admitted)  Emergency room Eacility fee (waived if admitted)  Emergency room Eacility fee (waived if admitted)  No charge  Emergency room Eacility fee (waived if admitted)  No charge  Emergency room physician fee (waived if admitted)  Urgent care  S35  Weed  Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Weetal/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Substance  Substance Use disorder outpatient office visits  No charge  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Preventive Substance Use disorder outpatient physician fee  20%  X  Substance Use disorder outpatient physician fee  20%  Y  Substance Use disorder outpatient physician fee  20%  X  Substance Use diso		Specialist visit		\$75		
Laboratory Pests  Laboratory Pests  Laboratory Pests  Laboratory Pests  Trer 1  Ter 1  Ter 1  Ter 1  Ter 1  Ter 2  \$55  Pharm deduct  Ter 3  \$80  Pharm deduct  Ter 3  \$80  Pharm deduct  Ter 3  \$80  Pharm deduct  Ter 4  20% up to \$250 per script after pharmacy deduct  deductible  Suggery facility fee (e.g., ASC) Physician/surgeon fees  Outpalient visit  Emergency room Eacility fee (waived if admitted)  Emergency room Eacility fee (waived if admitted)  Emergency room Eacility fee (waived if admitted)  No charge  Emergency room Eacility fee (waived if admitted)  No charge  Emergency room physician fee (waived if admitted)  Urgent care  S35  Weed  Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Weetal/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Substance  Substance Use disorder outpatient office visits  No charge  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Preventive Substance Use disorder outpatient physician fee  20%  X  Substance Use disorder outpatient physician fee  20%  Y  Substance Use disorder outpatient physician fee  20%  X  Substance Use diso						
Ter 1 \$15 Pharm deduct form of the condition of the condi			nmunization		_	
Tier 1 \$15 Pharm deduct lines or recondition  Tier 2 \$55 Pharm deduct lines or recondition  Tier 3 \$80 Pharm deduct lines or recondition  Tier 4 \$20% up to \$250 per script after pharmacy deductible. The recondition of the phase of the phas	Γests	X-rays and Diagnostic Imagin		\$75		
Tier 2  S55 Pharm deduct lines or Terr 3  S80 Pharm deduct lines or Terr 3  S80 Pharm deduct lines or Terr 4  Surgery facility tee (e.g., ASC) — 20% up to \$250 per script after pharmacy deductible project lines or S80 Pharm deduct lines or S80 Pharm deduct lines or S80 Pharm deduct lines or S80 Pharmacy facility tee (e.g., ASC) — 20% project lines or S80 Pharmacy deductible project lines or S80 Pharmacy facility for the S8			5)		Pharmacy	
Pare		Tier 1		\$15	deductible	
Tier 4 Sego deduct  Tier 4 Script after pharmacy obschucibble  Surgery facility fee (e.g., ASC) 20% up to \$250 per script after pharmacy obschucibble  Surgery facility fee (e.g., ASC) 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%	Ilness or	Tier 2		\$55	deductible	
Tier 4   Script after pharmacy deductible Surgery facility fee (e.g., ASC)   20%   2	condition	Tier 3			Pharmacy deductible	
Department   Physician/surgeon fees   20%				script after pharmacy deductible	Pharmacy deductible	
Cutpatient visit   20%	Outpatient		)			
Emergency room physician fee (waived if admitted)   No charge	services					
Emergency medical transportation \$250 X  Immediate intention		Emergency room facility fee (	waived if admitted)	\$350		
### Emergency medical transportation   \$250		Emergency room physician fe	e (waived if admitted)	No charge		
Urgent care				\$250	Х	
Mental/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  20%  X  Mental/Behavioral health inpatient physician fee  20%  X  Substance Use disorder outpatient office visits  Substance Use disorder outpatient facility fee (e.g. hospital room)  20%  X  Substance Use disorder inpatient physician fee  20%  X  Substance use disorder inpatient physician fee  20%  X  Delivery and all inpatient physician fee  Delivery and all inpatient physician fee  Durable medical equipment physician fee  Outpatient Habilitation services  335  Outpatient Habilitation services  336  Outpatient Habilitation services  337  Outpatient Habilitation services  338  Outpatient Habilitation services  339  Outpatient Habilitation services  330  Outpatient Habilitation services  335  Outpatient Habilitation services  336  Outpatient Habilitation services  337  Outpatient Habilitation services  337  Outpatient Habilitation services  338  Outpatient Habilitation services  339  Outpatient Habilitation services  330  Outpatient Habilitation services  335  Outpatient Habilitation services  336  Outpatient Habilitation services  337  Outpatient Habilitation services  338  Outpatient Habilitation services  339  Outpatient Habilitation service	attention	Urgent care		\$35		
Physician/surgeon fee 20% X  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% X  Mental/Behavioral health inpatient facility fee (e.g.,hospital room) 20% X  Mental/Behavioral health inpatient physician fee 20% X  Mental/Behavioral health inpatient physician fee 20% X  Substance Use disorder outpatient office visits \$35  Substance Use disorder outpatient items and services \$35  Substance Use disorder inpatient physician fee 20% X  Substance use disorder inpatient physician fee 20% X  Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient services Professional 20% X  Help Council Home health care (cost share per visit) 345  Outpatient Rehabilitation services 335  Outpatient Habilitation services 335  Outpatient Rehabilitation services 335  Child over care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) Not Covered 1 pair of glasses Periodontial Maintenance Services Not Covered 1 pair of glasses Periodontics Not Covered 1 pair of glasses Periodontics Not Covered 1 periodontal Maintenance Services 1 periodontal Maintenance Services 1 periodontal Maintenance Periodontics Not Covered 1 periodontics Not Covered 1 periodontics Not Covered 1 periodontal Maintenance Services 1 periodontal Maintenance Services 1 periodontal Maintenance Services 1 periodontal Maintenance Services 1 periodontal Maintenance Servi	Hospital stay	Facility fee (e.g. hospital room	1)	20%	Х	
Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g.hospital room)  Mental/Behavioral health inpatient facility fee (e.g.hospital room)  Mental/Behavioral health inpatient physician fee  20% X  Mental/Behavioral health inpatient physician fee  20% X  Mental/Behavioral health inpatient physician fee  20% X  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  20% X  Substance use disorder inpatient physician fee  20% X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Professional  20% X  Home health care (cost share per visit)  Substance use disorder inpatient physician fee  20% X  Substance use disorder inpatient physician fee  20% X  Prenatal care and preconception visits  No charge  Professional  20% X  Substance use disorder inpatient physician fee  20% X  X  Substance use disorder inpatient physician fee  20% X  X  Substance use disorder inpatient physician fee  20% X  X  Substance use disorder inpatient physician fee  20% X  X  Substance use disorder inpatient physician fee  20% X  X  Substance use disorder inpatient physician fee  20% X  X  Substance use disorder physician fee  20% X  X  Substance use disor	roopital otay	Physician/surgeon fee		20%	Х	
Mental/Behavioral health inpatient facility fee (e.g.hospital room)  Mental/Behavioral health inpatient physician fee  20% X  Mental/Behavioral health inpatient physician fee  20% X  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  20% X  Substance Use disorder inpatient physician fee  20% X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Professional  40% X  Home health care (cost share per visit)  Outpatient Rehabilitation services  335  Skilled nursing care  Durable medical equipment  Hospice service  Durable medical equipment  Hospice service  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Child Dental  Diagnostic  Child Dental  Basic  Restorative Procedures  Periodontics (other than maintenance)  Prosthodontics		Mental/Behavioral health outpatient office visits		\$35		
Mental Behavioral health, behavioral health inpatient physician fee  behavioral health, or substance abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient Hospital 20% X  Home health care (cost share per visit)  Home health care (cost share per visit)  Substance Use inpatient Hospital 20% X  Professional 20% X  Home health care (cost share per visit)  Outpatient Habilitation services 335  Skilled nursing care 20% X  Substance Use inpatient Hospital 20% X  Home health care (cost share per visit)  Nother special health needs  Substance Use inpatient Hospital 20% X  Mo charge 20% X  Child Dental Diagnostic and Child Dental Basic Sealants per Tooth  Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Restorative Procedures  Periodonica Influence Services  Crowns and Casts  Endodornics  Crowns and Casts  Endodornics  Crowns and Casts  Endodornics  Prosothodornics		Mental/Behavioral health other outpatient items and services		\$35		
Mental Behavioral health, behavioral health inpatient physician fee  behavioral health, or substance abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient Hospital 20% X  Home health care (cost share per visit)  Home health care (cost share per visit)  Substance Use inpatient Hospital 20% X  Professional 20% X  Home health care (cost share per visit)  Outpatient Habilitation services 335  Skilled nursing care 20% X  Substance Use inpatient Hospital 20% X  Home health care (cost share per visit)  Nother special health needs  Substance Use inpatient Hospital 20% X  Mo charge 20% X  Child Dental Diagnostic and Child Dental Basic Sealants per Tooth  Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Restorative Procedures  Periodonica Influence Services  Crowns and Casts  Endodornics  Crowns and Casts  Endodornics  Crowns and Casts  Endodornics  Prosothodornics		Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	
Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Delivery and all inpatient physician fee  Delivery and all inpatient physician fee  Hospital 20% X  Professional 20% X  Home health care (cost share per visit) \$45  Outpatient Rehabilitation services \$35  Skilled nursing care 20% X  Durable medical equipment 40 Pospica service 40 Pospica service 40 Pospica service 40 Pospica service 50 Pospica full footnate of the physician fee 40 Pospica service 50 Pospica full footnate for the physician fee 50 Pospica full footnate full footnate footnate full footnate full footnate footnate full footnate full footnate full footnate footnate full footnate full footnate footnate full full full full full full full ful				20%	Y	
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Pregnancy  Prenatal care and preconception visits  No charge  Preventive Substance use disorder inpatient physician fee  20%  X  Hospital 20%  X  Hospital 20%  X  Professional 20%  X  445  Outpatient Rehabilitation services  \$35  Skilled nursing care 90%  Valupatient Habilitation services  Skilled nursing care 20%  X  Durable medical equipment 40%  Hospice service No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  No charge  No charge  Not Covered  Preventive - Cleaning  Preventive - Cleaning  Space Maintainers - Fixed  Not Covered  Proventive Procedures  Periodontic Maintenance Services  Crowns and Casts  Endodontics  Proventive Core than maintenance)  Proventive Covered	nealth, or substance					
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Pregnancy  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Home health care (cost share per visit)  Cutpatient Habilitation services  Sa5  Outpatient Habilitation services  Sa5  Skilled nursing care  Suited nursing care  Child eye care  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Preventive - Cleaning  Not Covered  Space - Maintainers - Fixed  Not Covered  Space - Crows and Casts  Endodonics  Crows and Casts  Endodonics  Prosthodonics (other than maintenance)  Prosthodonics  Prosthodonics		Substance Use disorder other outpatient items and services		\$35		
Substance use disorder inpatient physician fee 20% X  Prenatal care and preconception visits No charge  Pregnancy Delivery and all inpatient services Professional 20% X  Home health care (cost share per visit) \$45  Outpatient Rehabilitation services \$35  Outpatient Habilitation services \$35  Outpatient Habilitation services \$35  Durable medical equipment 20% X  Hospice service No charge No charge Eye exam No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Child eye care  Child Dental Diagnostic and Space Maintainers - Fixed  Child Dental Basic Restorative Procedures  Restorative Procedures  Crowns and Castis Endodontics Previous V Professional 20% X  Ax  Diagnostic Available Application Space Maintainers - Fixed  Child Dental Basic Services  Crowns and Castis Endodontics Previous V Periodontics (other than maintenance)  Not Covered  Previous V Prosthodontics  Not Covered  Not Covered  Not Covered  Prosthodontics  Prosthodontics			· 			
Pregnancy Pregnancy Pregnancy Delivery and all inpatient services Professional Hospital Home health care (cost share per visit) Professional Home health care (cost share per visit) S45 Outpatient Rehabilitation services 335 Outpatient Habilitation services 336 Outpatient Habilitation services 337 Outpatient Habilitation services 336 Outpatient Habilitation services 337 Outpatient Habilitation services 337 Outpatient Habilitation services 336 Outpatient Habilitation services 337 Outpatient Habilitation services No charge Durable medical equipment Hospice service No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Child Dental Diagnostic Preventive - Cleaning Prevent						
Pregnancy Services Delivery and all inpatient services Professional Professional 20% X  Professional 20% X  Home health care (cost share per visit) \$45  Outpatient Rehabilitation services \$35  Outpatient Habilitation servi					Х	
services Professional 20% X  Home health care (cost share per vist) \$45  Outpatient Rehabilitation services \$35  Outpatient Habilitation services \$35  Skilled nursing care 20% X  Durable medical equipment 20%  Hospice service No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam Preventive - Cleaning Preventive - Veray Not Covered Sealants per Tooth Preventive No pace Maintainers - Fixed Not Covered Space Maintainers - Fixed Not Covered Space Maintainers - Fixed Periodontal Maintenance Services Periodonticis (other than maintenance)  Periodontics Not Covered Prosthodontics						
Home health care (cost share per visit)  Quipatient Rehabilitation services S 35 Outpatient Rehabilitation services S 35 Outpatient Rehabilitation services S 35 Outpatient Rehabilitation services S 35 Skilled nursing care Durable medical equipment Hospice service No charge Eye exam No charge Preventive - Cleaning Preventive - Cleaning Preventive - Veray Services Periodontal Maintenance Services Not Covered Space Maintainers - Fixed Child Dental Basic Child Dental Basic Crowns and Casts Endodontics Periodontics Proceditios Proced			i i	***		
Dupatient Rehabilitation services   \$35		Home health care (cost share			X	
Skilled nursing care 20% X  Durable medical equipment 20% No charge 20%		Outpatient Rehabilitation serv	ices			
health needs Durable medical equipment Hospice service Eve exam Child eye care 1 pair of glasses per year (or contact tenses in lieu of glasses) No charge 1 pair of glasses per year (or contact tenses in lieu of glasses) No charge 1 pair of glasses per year (or contact tenses in lieu of glasses) No charge  Oral Exam Preventive - Cleaning Preventive - V-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontial Maintenance Services Crowns and Casts Endodontics Crowns and Casts Endodontics Prosthodontics Prosthodontics Prosthodontics Prosthodontics			~		У	
Hospice service  Posterior Services  Hospice service  Prosentive - Cleaning Preventive -					_^	
1 pair of glasses per year (or contact tenses in lieu of glasses)   No charge		Hospice service		No charge		
Total County   Total County	Child eye care		contact lenses in lieu of alasses)			
Preventive - Cleaning   Diagnostic   Preventive - Cleaning   Diagnostic   Preventive - Cleaning   Diagnostic   Preventive - Cray   Sealants per Tooth   Diagnostic   Preventive - Copical Fluoride Application   Space Maintainers - Fixed   Diagnost   Procedures   Periodontal Maintenance Services   Periodontal Maintenance Services   Diagnostic   Procedures			contact renses in neu or grasses)	ino charge		
Sealants per Tooth		Preventive - Cleaning				
Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Restorative Procedures Periodonal Maintenance Services Crowns and Casts Endodonal Maintenance Services Periodonics (other than maintenance) Prosthodonics Prosthodonics			Not Covered			
Child Dental Bestorative Procedures Not Covered Bestvices Periodontal Maintenance Services Prodontics Not Covered Crowns and Casts Endodontics Periodontics (other than maintenance) Not Covered Prosthodontics		Topical Fluoride Application				
Services Restorative Procedures Not Covered  Services Periodontal Maintenance Services Crowns and Casts Endodontics Major Periodontics (other than maintenance) Prosthodontics Prosthodontics	Child Dental					
Crowns and Casts Child Dental Major Periodontics (other than maintenance) Prosthodontics Prosthodontics	Basic			Not Covered		
Child Dental Major Periodontics (other than maintenance) Not Covered Services Prosthodontics			vices		_	
Services Prosthodontics	Child Dental	Endodontics				
Ural Surgery	Services	Prosthodontics	tenance)	Not Covered		
Child		Oral Surgery				

Summary of	Renefits and Coverage		CCSB		CCSB	
Summary of Benefits and Coverage			Silver		Silver	
	Member Cost Share amounts describe the Enrollee's out of pocket costs.  Actuarial Value - AV Calculator		Coinsurance Plan		Copay Plan	
			71.9%		71.4%	
Integrated In	Plan design includes a deductible? Integrated Individual deductible		Yes, Medical/Pharmacy N/A		Yes, Medical/Pharmacy N/A	
	amily deductible ductible, NOT integrated: M	edical / Pharmacy / Dental	N/A \$2,000 / \$125 / \$0		N/A \$2,000/ \$125 / \$0	
Family deduc	ctible, NOT integrated: Medi		\$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	So	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	njury, illness, or condition	\$45		\$45	
Health care provider's office or clinic	Other practitioner office visit		\$45		\$45	
visit	Specialist visit		\$75		\$75	
	Preventive care/ screening/ i	mmunization	No charge		No charge	
Tests	Laboratory Tests  X-rays and Diagnostic Imagir	a	\$40 \$70		\$40 \$70	
	Imaging (CT/PET scans, MR		20%		\$300	
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmac; deductible
Drugs to treat	Tier 2		\$55	Pharmacy deductible	\$55	Pharmac; deductible
illness or condition	Tier 3		\$85	Pharmacy deductible	\$85	Pharmac; deductible
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy deductible	20% up to \$250 per script after pharmacy	Pharmacy
Outre	Surgery facility fee (e.g., ASC	:)	deductible 20%		deductible 20%	
Outpatient services	Physician/surgeon fees		20%		20%	
	Outpatient visit	waived if admitted)	20%		20%	
	Emergency room facility fee (		\$350		\$350	
Need	Emergency room physician fo		No charge		No charge	
mmediate attention	Emergency medical transport	ation	\$250	Х	\$250	Х
attention	Urgent care		\$45		\$45	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	Х	20%	Х
	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health outpatient office visits		\$45		\$45	
	Mental/Behavioral health other outpatient items and services		\$45		\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	Х	20%	х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee		20%	Х	20%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$45		\$45	
	Substance Use disorder other outpatient items and services		\$45		\$45	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	X	20%	Х
	Substance use disorder inpar	ient physician fee	20%	X	20%	Х
	Prenatal care and preconcep		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	Х
	services	Professional	20%	X	20%	Х
lala.	Home health care (cost share Outpatient Rehabilitation service)		20% \$45		\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45		\$45	
other special	Skilled nursing care		20%	Х	20%	Х
health needs	Durable medical equipment Hospice service		20% No charge		20% No charge	
20.21.4	Eye exam		No charge		No charge	
Child eye care	i pail of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning		1			
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Ser	vices			Not Course	
Child Dental	Crowns and Casts Endodontics				Not Covered Not Covered	
Major	Periodontics (other than mair	tenance)	Not Covered		Not Covered	
Services	Prosthodontics				Not Covered	
Child	Oral Surgery				Not Covered	
Orthodontics	Medically necessary orthodo	ntics	Not Covered		Not Covered	

	Benefits and Coverage		CCSB		
	hare amounts describe the En	rollee's out of pocket costs.	Silver HDHP Plan		
	e - AV Calculator		71.7%		
Integrated Inc	cludes a deductible? dividual deductible		Yes, integr \$2,000 integ	grated	
Integrated Fa Individual de	mily deductible ductible, NOT integrated: Me	edical / Pharmacy / Dental	\$4,000 integ N/A	rated	
	ctible, NOT integrated: Medic	al / Pharmacy / Dental	N/A \$6,550	)	
Family Out-of-	pocket maximum		\$13,100 \$2,000	0	
HSA family pla	only coverage deductible n: Individual deductible		\$2,600		
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an in	njury, illness, or condition	20%	Х	
Health care provider's office or clinic visit	Other practitioner office visit		20%	Х	
	Specialist visit		20%	х	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge 20%	X	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		20% 20%	X	
	Tier 1	)	20% up to \$250 per	×	
			script 20% up to \$250 per		
Drugs to treat	Tier 2		script	X	
condition	Tier 3		20% up to \$250 per script	Х	
	Tier 4		20% up to \$250 per script	X	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	<u> </u>	20% 20%	X	
services	Outpatient visit		20%	Х	
	Emergency room facility fee (v	vaived if admitted)	20%	Х	
Need	Emergency room physician fe		0%	X	
immediate attention	Emergency medical transportation		20%	X	
	Urgent care		20%	Х	
Hospital stay	Facility fee (e.g. hospital room	)	20%	X	
	Physician/surgeon fee  Mental/Behavioral health outpatient office visits		20%	X	
	Mental/Behavioral health other outpatient items and services		20%	х	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	X	
Mental health, behavioral	Mental/Behavioral health inpa		20%	X	
health, or substance abuse needs	Substance Use disorder outpatient office visits		20%	×	
abuse needs					
		outpatient items and services	20%	Х	
	Substance Use inpatient facili		20%	Х	
	Substance use disorder inpati		20%	Х	
Pregnancy	Prenatal care and preconcept  Delivery and all inpatient		No charge 20%	X	
. regnancy	services	Hospital Professional	20%	X	
	Home health care (cost share Outpatient Rehabilitation serv	per visit)	20% 20%	X	
Help recovering or	Outpatient Rehabilitation service		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 o	contact lenses in lieu of glasses)	No charge		
Child Dental	Oral Exam Preventive - Cleaning				
Diagnostic and	Preventive - X-ray		Not Covered		
Preventive	Sealants per Tooth Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic Services	Restorative Procedures		Not Covered		
C31 11003	Periodontal Maintenance Sen Crowns and Casts	rices			
Child Dental	Endodontics		No. 0		
Major Services	Periodontics (other than main Prosthodontics Oral Surgery	enance)	Not Covered		
Child Orthodontics	Medically necessary orthodon	tics	Not Covered		
JJuonius					

Summary	of Be	enefits	and	Coverage

	ummary of Benefits and Coverage ember Cost Share amounts describe the Enrollee's out of pocket costs.		Silver F 100%-150		Silver Plan 150%-200% FPL		
	e - AV Calculator		93.99	%	88.0%		
	cludes a deductible? dividual deductible		Yes, Medical/I		Yes, Medical/Pha N/A	rmacy	
Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental			N/A \$75 / \$0 / \$0		N/A		
Family deduc	ctible, NOT integrated: Medic		\$150 / \$0	0 / \$0	\$650 / \$50 / \$0 \$1,300 / \$100 / \$0		
	-of-pocket maximum pocket maximum		\$1,00 \$2,00		\$2,450 \$4,900		
HSA plan: Self-	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A		
Common Medical Event	Se	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an ir	ajury, illness, or condition	\$5		\$10		
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$10		
	Specialist visit		\$8		\$25		
	Preventive care/ screening/ in Laboratory Tests	munization	No charge \$8		No charge \$15		
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$8 \$50		\$25 \$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	
Outpatient	Surgery facility fee (e.g., ASC)		10%		deductible 15%		
services	Physician/surgeon fees Outpatient visit		10% 10%		15% 15%		
	Emergency room facility fee (v	vaived if admitted)	\$50		\$100		
	Emergency room physician fe	(waived if admitted)	No charge		No charge		
Need immediate	Emergency medical transporta	* * * * * * * * * * * * * * * * * * * *	\$30	X	\$75	X	
attention	Urgent care		\$5		\$10		
Hospital stay	Facility fee (e.g. hospital room	)	10%	Х	15%	Х	
	Physician/surgeon fee		10%	X	15%	X	
	Mental/Behavioral health outpatient office visits		\$5		\$10		
	Mental/Behavioral health other outpatient items and services		\$5		\$10		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	Х	15%	Х	
Mental health, behavioral	Mental/Behavioral health inpatient physician fee		10%	Х	15%	Х	
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$5		\$10		
	Substance Use disorder other	\$5		\$10			
	Substance Use inpatient facility fee (e.g. hospital room)		10%	Х	15%	Х	
	Substance use disorder inpatient physician fee		10%	х	15%	х	
	Prenatal care and preconcept	on visits	No charge		No charge		
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	х	
	services  Home health care (cost share	Professional	10% \$3	X	15% \$15	X	
Help	Outpatient Rehabilitation servi	ces	\$5		\$10		
recovering or	Outpatient Habilitation service	S	\$5		\$10		
other special health needs	Skilled nursing care		10%	Х	15%	Х	
	Durable medical equipment Hospice service		10% No charge		15% No charge		
Child eye care	Eye exam		No charge		No charge		
	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge		No charge		
Child Dental	Oral Exam Preventive - Cleaning		1				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered			
Preventive	Sealants per Tooth Topical Fluoride Application		4				
Child Dental	Space Maintainers - Fixed						
Basic	Restorative Procedures		Not Covered		Not Covered		
Services	Periodontal Maintenance Service Crowns and Casts	ices		$\vdash$		_	
Child Dental	Endodontics		4				
Major Services	Periodontics (other than maint	enance)	Not Covered		Not Covered		
COLVICES	Prosthodontics Oral Surgery		4				
	Child						
Child	Medically necessary orthodon	tion	Not Covered		Not Covered		

### 2018 Patient-Centered Benefit Plan Designs 9.5 EHB

	Benefits and Cov hare amounts describe	the Enrollee's out of pocket costs.	Silver Plan			
	e - AV Calculator	The Employed dat of poored doors.	200%-250% FF 73.9%	PL		
Plan design in	cludes a deductible?		Yes, Medical/Phar	macy		
	dividual deductible mily deductible		N/A N/A			
Individual de	ductible, NOT integra	ted: Medical / Pharmacy / Dental : Medical / Pharmacy / Dental	\$2,200 / \$130 / \$4,400 / \$260 /			
Individual Out-	-of-pocket maximum		\$5,850	φυ		
HSA plan: Self	pocket maximum -only coverage deduc	tible	\$11,700 N/A			
HSA family pla	n: Individual deductib	ole	N/A			
Common Medical Event		Service Type	Member Cost Share	Deductibl Applies		
	Primary care visit to tre	eat an injury, illness, or condition	\$30			
Health care provider's office or clinic	Other practitioner offic	e visit	\$30			
visit	Specialist visit		\$75			
	Preventive care/ scree	ening/ immunization	No charge			
Tests	Laboratory Tests X-rays and Diagnostic	Imaging	\$35 \$75			
	Imaging (CT/PET scar	ns, MRIs)	\$300	Di		
	Tier 1		\$15	Pharmac		
Drugs to treat illness or	Tier 2		\$50	Pharmac deductible		
condition	Tier 3		\$75	Pharmac deductibl		
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac deductibl		
Outpatient	Surgery facility fee (e.g Physician/surgeon fee		20%			
services	Outpatient visit		20%			
	Emergency room facili	ty fee (waived if admitted)	\$350			
Need		sician fee (waived if admitted)	No charge			
immediate	Emergency medical tra	ansportation	\$250	Х		
attention	Urgent care		\$30			
Hospital stay	Facility fee (e.g. hospit	tal room)	20%	Х		
	Physician/surgeon fee		20%	X		
	Mental/Behavioral health outpatient office visits		\$30			
	Mental/Behavioral health other outpatient items and services		\$30			
Mental health,	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	Х		
behavioral health, or	Mental/Behavioral hea	alth inpatient physician fee	20%	Х		
substance abuse needs	Substance Use disord	er outpatient office visits	\$30			
	Substance Use disord	er other outpatient items and services	\$30			
	Substance Use inpatie	ent facility fee (e.g. hospital room)	20%	Х		
		er inpatient physician fee	20%	Х		
December	Prenatal care and pred		No charge			
Pregnancy	Delivery and all inpation services	Hospital Professional	20%	X		
	Home health care (cos	st share per visit)	\$40			
Help	Outpatient Rehabilitati Outpatient Habilitation		\$30 \$30			
recovering or other special	Skilled nursing care		20%	Х		
health needs	Durable medical equipment		20%			
01:11	Hospice service Eye exam		No charge No charge			
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		No charge			
Child Dental			7			
Diagnostic and			Not Covered			
Preventive	Topical Fluoride Applic					
Child Dental	Space Maintainers - F					
Basic Services	Periodontal Maintenan		Not Covered			
Child Dental	Crowns and Casts Endodontics					
Major	Periodontics (other that	an maintenance)	Not Covered			
Services	Prosthodontics					

Medically necessary orthodontics

Not Covered

	hare amounts describe the Enrollee's out of pocket costs.		Bronze Plan		
	e - AV Calculator	60.8% Yes, Medical/Pha	61.4%		
Plan design includes a deductible? Integrated Individual deductible		N/A	ппасу	Yes, integrated \$4,800 integrated	
	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$6,300 / \$500	\$9,600 integrated N/A		
Family deduc	ctible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,00 \$7,000		N/A	
amily Out-of-	-of-pocket maximum pocket maximum	\$7,000 \$14,000		\$6,55 \$13,10	
	-only coverage deductible In: Individual deductible	N/A N/A		\$4,80 \$4,80	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				71,00	
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	
	Laboratory Tests X-rays and Diagnostic Imaging	\$40 100%	X	40% 40%	X
	Imaging (CT/PET scans, MRIs)	100%	X	40%	Х
	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
illness or 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)	100% 100%	X	40% 40%	X
services	Physician/surgeon fees Outpatient visit	100%	X	40%	X
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need immediate	Emergency medical transportation	100%	X	40%	X
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)	100%	Х	40%	Х
	Physician/surgeon fee	100%	X	40%	X
	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
Mental health,	Mental/Behavioral health inpatient physician fee	100%	X	40%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	\$75	х	40%	х
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X
	Substance use disorder inpatient physician fee	100%	X	40%	X
	Prenatal care and preconception visits	No charge	^	No charge	_^
	Delivery and all inpatient Hospital	100%	Х	40%	Х
	services Professional	100%	X	40%	X
	Home health care (cost share per visit)	100%	X	40%	X
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$75 \$75		40% 40%	X
recovering or	Skilled nursing care	100%	Х	40%	Х
haalth naade	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge		0%	X
Child ave ages	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge  No charge		No charge No charge	
	Oral Exam	. 10 0112190		onargo	
Child Dental	Preventive - Cleaning				
and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application	Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services Crowns and Casts				
	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics Oral Surgery				
Child	Oral Surgery				
	Medically necessary orthodontics	Not Covered		Not Covered	

	hare amounts describe the Enrollee's out of pocket costs.	Catastro	phic Plan	
	- AV Calculator	Van int		
	cludes a deductible? dividual deductible		egrated ntegrated	
Integrated Fa	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental		ntegrated /A	
Family deduc	tible, NOT integrated: Medical / Pharmacy / Dental	N	/A	
	of-pocket maximum		350 ,700	
HSA plan: Self	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	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 X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
	Tier 1	0%	Х	
Drugs to treat	Tier 2	0%	х	
condition	Tier 3	0%	х	
	Tier 4	0%	х	
Outpatient	Surgery facility fee (e.g., ASC)	0%	X	
services	Physician/surgeon fees Outpatient visit	0%	X	
	Emergency room facility fee (waived if admitted)	0%	X	
			^	
Need	Emergency room physician fee (waived if admitted)	No charge		
immediate	Emergency medical transportation	0%	Х	
attention	Urgent care	0%	After 1st three non-preventive visits	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	0%	X X	
	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits	
	Mental/Behavioral health other outpatient items and services	0%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	х	
Mental health,	Mental/Behavioral health inpatient physician fee	0%	Х	
behavioral 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	
,	services Professional	0%	X	
	Home health care (cost share per visit)	0%	Х	
Help	Outpatient Rehabilitation services Outpatient 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 care	Eye exam	No charge		
2,2 00.10	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	preventive - X-ray			
and Preventive	Sealants per Tooth	Not Covered		
	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental	Restorative Procedures	Not Covered		
Basic Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
Child Dental	Endodontics			
Major	Periodontics (other than maintenance)	Not Covered		
	Prostriodoritics			
Services				
Child	Oral Surgery  Medically necessary orthodontics	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,XXX 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;
	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.
	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.