

Covered California ~~2018~~2019 Patient-Centered Benefit Plan Designs¹

~~Final Proposed~~ Board-approved
~~June 15, 2017²~~³ January 18, 2018

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

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

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

20182019 Patient-Centered Benefit Plan Designs

10.0 EHB

Date: June 15, 2017January 18, 2018



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator		91.2%91.7%	88.1%88.9%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$3,350	\$3,350
Family Out-of-pocket maximum		\$6,700	\$6,700
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
	Other practitioner office visit	\$15		\$15	
	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$15		\$15	
	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
Drugs to treat illness or condition	Tier 1	\$5		\$5	
	Tier 2	\$15		\$15	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$100	
	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency room Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	10%		No charge	
	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatient physician fee	10%		No charge	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation services	\$15		\$15	
	Outpatient Habilitation services	\$15		\$15	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures	20%		See 20182019 Dental Copay Schedule	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts	50%		See 20182019 Dental Copay Schedule	
	Endodontics				
	Periodontics (other than maintenance)				
	Prosthodontics				
Child Orthodontics	Oral Surgery	50%		\$1,000	
	Medically necessary orthodontics				

2018/2019 Patient-Centered Benefit Plan Designs

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Date: ~~June 15, 2017~~ **January 18, 2018**

Summary of Benefits and Coverage

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

		Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator		81.8%	78.4% 78.1%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$8,000 \$7,200	\$8,000 \$7,200
Family Out-of-pocket maximum		\$12,000 \$14,400	\$12,000 \$14,400
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$25 \$30		\$25 \$30	
	Other practitioner office visit	\$25 \$30		\$25 \$30	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
Drugs to treat illness or condition	Tier 1	\$15		\$15	
	Tier 2	\$55		\$55	
	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		\$300	
	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$325		\$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency room Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$25 \$30		\$25 \$30	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$25 \$30		\$25 \$30	
	Mental/Behavioral health other outpatient items and services	\$25 \$30		\$25 \$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	20%		No charge	
	Substance Use disorder outpatient office visits	\$25 \$30		\$25 \$30	
	Substance Use disorder other outpatient items and services	\$25 \$30		\$25 \$30	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician fee	20%		No charge	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	\$600 per day up to 5 days	
		Professional	20%	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	20%		\$30	
	Outpatient Rehabilitation services	\$25 \$30		\$25 \$30	
	Outpatient Habilitation services	\$25 \$30		\$25 \$30	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures	20%		See 2018/2019 Dental Copay Schedule	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts	50%		See 2018/2019 Dental Copay Schedule	
	Endodontics				
	Periodontics (other than maintenance)				
	Prosthodontics				
Child Orthodontics	Oral Surgery				
	Medically necessary orthodontics	50%		\$1,000	

2018 Patient-Centered Benefit Plan Designs

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Summary of Benefits and Coverage

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

	Individual
	Silver Plan
Actuarial Value - AV Calculator	71.9% / 71.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated individual deductible	N/A
Integrated family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$130 / \$200 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$260 / \$400 / \$0
Individual Out-of-pocket maximum	\$7,000 / \$7,550
Family Out-of-pocket maximum	\$14,000 / \$15,100
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$35/\$40		
	Other practitioner office visit	\$35/\$40		
	Specialist visit	\$75/\$80		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$75		
	Imaging (CT/PET scans, MRIs)	\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$55	Pharmacy deductible	
	Tier 3	\$80	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency room Medical transportation (including emergency and non-emergency)	\$250	X	
	Urgent care	\$35/\$40		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$35/\$40		
	Mental/Behavioral health other outpatient items and services	\$35/\$40		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$35/\$40		
	Substance Use disorder other outpatient items and services	\$35/\$40		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$45		
	Outpatient Rehabilitation services	\$35/\$40		
	Outpatient Habilitation services	\$35/\$40		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive	Oral Exam	No charge		
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed			
	Restorative Procedures	20%		
Child Dental Major Services	Periodontal Maintenance Services			
	Crowns and Casts	50%		
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		

2018-2019 Patient-Centered Benefit Plan Designs

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Summary of Benefits and Coverage

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

	CCSB	CCSB
	Silver Coinsurance Plan	Silver Copay Plan
Actuarial Value - AV Calculator	71.9%	71.4%/71.6%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$125\$200 / \$0	\$2,000 / \$125\$200 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$250\$400 / \$0	\$4,000 / \$250\$400 / \$0
Individual Out-of-pocket maximum	\$7,000\$7,550	\$7,000\$7,550
Family Out-of-pocket maximum	\$14,000\$15,100	\$14,000\$15,100
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45		\$45		
	Other practitioner office visit	\$45		\$45		
	Specialist visit	\$75\$80		\$75\$80		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$40		\$40		
	X-rays and Diagnostic Imaging	\$70\$75		\$70\$75		
	Imaging (CT/PET scans, MRIs)	20%		\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	\$15	Pharmacy deductible	
	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible	
	Tier 3	\$85	Pharmacy deductible	\$85	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%		
	Physician/surgeon fees	20%		20%		
	Outpatient visit	20%		20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		\$350		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Emergency medical transportation (including emergency and non-emergency)	\$250	X	\$250	X	
	Urgent care	\$45		\$45		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%	X	20%	X	
Mental health, behavioral health, or substance abuse needs	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%	X	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	20%	X	
	Substance Use disorder outpatient office visits	\$45		\$45		
	Substance Use disorder other outpatient items and services	\$45		\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	20%	X	
	Substance use disorder inpatient physician fee	20%	X	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	20%		\$45		
	Outpatient Rehabilitation services	\$45		\$45		
	Outpatient Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
Child eye care	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	No charge		No charge		
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
Topical Fluoride Application						
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	20%		See 2018-2019 Dental Copay Schedule		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts					
	Endodontics					
	Periodontics (other than maintenance)	50%		See 2018-2019 Dental Copay Schedule		
Child Orthodontics	Prosthodontics					
	Oral Surgery					
	Medically necessary orthodontics	50%		\$1,000		

2018-2019 Patient-Centered Benefit Plan Designs

10.0 EHB

Date: June 15, 2017/January 18, 2018

Summary of Benefits and Coverage

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

	CCSB
	Silver HDHP Plan
Actuarial Value - AV Calculator	71.7% / 70.5%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	\$2,000 / \$2,500 integrated
Integrated Family deductible	\$4,000 / \$5,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out-of-pocket maximum	\$6,550 / \$6,650
Family Out-of-pocket maximum	\$13,400 / \$13,300
HSA plan: Self-only coverage deductible	\$2,000 / \$2,500
HSA family plan: Individual deductible	\$2,700

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	20%	X	
	Other practitioner office visit	20%	X	
	Specialist visit	20%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	20%	X	
	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Tier 1	20% up to \$250 per script	X	
	Tier 2	20% up to \$250 per script	X	
	Tier 3	20% up to \$250 per script	X	
	Tier 4	20% up to \$250 per script	X	
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%	X	
	Outpatient visit	20%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X	
	Emergency room physician fee (waived if admitted)	0%	X	
	Emergency room Medical transportation (including emergency and non-emergency)	20%	X	
	Urgent care	20%	X	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	20%	X	
	Mental/Behavioral health other outpatient items and services	20%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	20%	X	
	Substance Use disorder other outpatient items and services	20%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	20%	X	
	Outpatient Rehabilitation services	20%	X	
	Outpatient Habilitation services	20%	X	
	Skilled nursing care	20%	X	
	Durable medical equipment	20%	X	
	Hospice service	0%	X	
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive	Oral Exam	No charge		
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed			
	Restorative Procedures	20%		
Child Dental Major Services	Periodontal Maintenance Services	50%		
	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
Child Orthodontics	Oral Surgery			
	Medically necessary orthodontics	50%		

2018/2019 Patient-Centered Benefit Plan Designs

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Summary of Benefits and Coverage

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

		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL		
Actuarial Value - AV Calculator		93.9%	94.2%	88.0%	87.9%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		N/A		
Integrated Family deductible		N/A		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$75 / \$0 / \$0		\$650 / \$50 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$150 / \$0 / \$0		\$1,300 / \$100 / \$0		
Individual Out-of-pocket maximum		\$1,000		\$2,450/\$2,600		
Family Out-of-pocket maximum		\$2,000		\$4,900/\$5,200		
HSA plan: Self-only coverage deductible		N/A		N/A		
HSA family plan: Individual deductible		N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$40\$15		
	Other practitioner office visit	\$5		\$40\$15		
	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$8		\$15		
	X-rays and Diagnostic Imaging	\$8		\$25\$30		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
Drugs to treat illness or condition	Tier 1	\$3		\$5		
	Tier 2	\$10		\$20	Pharmacy deductible	
	Tier 3	\$15		\$35	Pharmacy deductible	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		15%		
	Physician/surgeon fees	10%		15%		
	Outpatient visit	10%		15%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$50		\$100		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Emergency medical transportation (including emergency and non-emergency)	\$30	X	\$75	X	
	Urgent care	\$5		\$40\$15		
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X	
	Physician/surgeon fee	10%	X	15%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$5		\$40\$15		
	Mental/Behavioral health other outpatient items and services	\$5		\$40\$15		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	X	15%	X	
	Mental/Behavioral health inpatient physician fee	10%	X	15%	X	
	Substance Use disorder outpatient office visits	\$5		\$40\$15		
	Substance Use disorder other outpatient items and services	\$5		\$40\$15		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	X	15%	X	
	Substance use disorder inpatient physician fee	10%	X	15%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$3		\$15		
	Outpatient Rehabilitation services	\$5		\$40\$15		
	Outpatient Habilitation services	\$5		\$40\$15		
	Skilled nursing care	10%	X	15%	X	
	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge		
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	20%		20%		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts	50%		50%		
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
Oral Surgery						
Child Orthodontics	Medically necessary orthodontics	50%		50%		

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10.0 EHB

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Summary of Benefits and Coverage

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

		Silver Plan 200%-250% FPL		
Actuarial Value - AV Calculator		73.9%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		
Integrated Family deductible		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$2,200 / \$430 / \$175 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$4,400 / \$260 / \$350 / \$0		
Individual Out-of-pocket maximum		\$5,850 / \$6,300		
Family Out-of-pocket maximum		\$11,700 / \$12,600		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$30/\$35		
	Other practitioner office visit	\$30/\$35		
	Specialist visit	\$75		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$75		
	Imaging (CT/PET scans, MRIs)	\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$50	Pharmacy deductible	
	Tier 3	\$75	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation (including emergency and non-emergency)	\$250	X	
	Urgent care	\$30/\$35		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$30/\$35		
	Mental/Behavioral health other outpatient items and services	\$30/\$35		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$30/\$35		
	Substance Use disorder other outpatient items and services	\$30/\$35		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$40		
	Outpatient Rehabilitation services	\$30/\$35		
	Outpatient Habilitation services	\$30/\$35		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
Child eye care	Hospice service	No charge		
	Eye exam	No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam	No charge		
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	20%		
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts	50%		
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
Child Orthodontics	Oral Surgery			
	Medically necessary orthodontics	50%		

2018-2019 Patient-Centered Benefit Plan Designs

10.0 EHB

Date: June 15, 2017 January 18, 2018

Summary of Benefits and Coverage

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

		Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator		60.9% 60.9%	61.4% 61.6%
Plan design includes a deductible?		Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible		N/A	\$4,800/\$6,000 integrated
Integrated Family deductible		N/A	\$9,600/\$12,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,300 / \$500 / \$0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,600 / \$1,000 / \$0	N/A
Individual Out-of-pocket maximum		\$7,000/\$7,550	\$6,560/\$6,650
Family Out-of-pocket maximum		\$14,000/\$15,100	\$13,100/\$13,300
HSA plan: Self-only coverage deductible		N/A	\$4,800
HSA family plan: Individual deductible		N/A	\$4,800

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	X	
	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	X	
	Specialist visit	\$105	After 1st three non-preventive visits	40%	X	
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$40		40%	X	
	X-rays and Diagnostic Imaging	100%	X	40%	X	
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
Drugs to treat illness or condition	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
Outpatient services	Surgery facility fee (e.g., ASC)	100%	X	40%	X	
	Physician/surgeon fees	100%	X	40%	X	
	Outpatient visit	100%	X	40%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	100%	X	40%	X	
	Emergency room physician fee (waived if admitted)	No charge		0%	X	
	Emergency room Medical transportation (including emergency and non-emergency)	100%	X	40%	X	
	Urgent care	\$75	After 1st three non-preventive visits	40%	X	
Hospital stay	Facility fee (e.g. hospital room)	100%	X	40%	X	
	Physician/surgeon fee	100%	X	40%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health other outpatient items and services	\$75	X	40%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	X	
	Mental/Behavioral health inpatient physician fee	100%	X	40%	X	
	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Substance Use disorder other outpatient items and services	\$75	X	40%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X	
	Substance use disorder inpatient physician fee	100%	X	40%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care (cost share per visit)	100%	X	40%	X	
	Outpatient Rehabilitation services	\$75		40%	X	
	Outpatient Habilitation services	\$75		40%	X	
	Skilled nursing care	100%	X	40%	X	
	Durable medical equipment	100%	X	40%	X	
	Hospice service	No charge		0%	X	
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge		
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	20%		20%		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts	50%		50%		
	Endodontics					
	Periodontics (other than maintenance)					
Prosthodontics						
Child Orthodontics	Oral Surgery					
	Medically necessary orthodontics	50%		50%		

20182019 Patient-Centered Benefit Plan Designs

10.0 EHB

Date: June 15, 2017 January 18, 2018

Summary of Benefits and Coverage

Member Share amounts describe the Enrollee's out of pocket costs.

		Catastrophic Plan		
Actuarial Value - AV Calculator				
Plan design includes a deductible?		Yes, integrated		
Integrated individual deductible		\$7,350\$7,900 integrated		
Integrated Family deductible		\$14,700\$15,800 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$7,350\$7,900		
Family Out-of-pocket maximum		\$14,700\$15,800		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits	
	Other practitioner office visit	0%	After 1st three non-preventive visits	
	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	0%	X	
	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
Drugs to treat illness or condition	Tier 1	0%	X	
	Tier 2	0%	X	
	Tier 3	0%	X	
	Tier 4	0%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X	
	Physician/surgeon fees	0%	X	
	Outpatient visit	0%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation (including emergency and non-emergency)	0%	X	
	Urgent care	0%	After 1st three non-preventive visits	
Hospital stay	Facility fee (e.g. hospital room)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health, behavioral health, or substance abuse needs	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%	X	
	Mental/Behavioral health inpatient physician fee	0%	X	
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits	
	Substance Use disorder other outpatient items and services	0%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care (cost share per visit)	0%	X	
	Outpatient Rehabilitation services	0%	X	
	Outpatient Habilitation services	0%	X	
	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
Child eye care	Hospice service	0%	X	
	Eye exam	No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X	
	Oral Exam			
Child Dental Diagnostic and Preventive	Preventive - Cleaning	No charge		
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures	0%	X	
	Periodontal Maintenance Services		X	
Child Dental Major Services	Crowns and Casts	0%	X	
	Endodontics		X	
	Periodontics (other than maintenance)		X	
	Prosthodontics		X	
	Oral Surgery		X	
Child Orthodontics	Medically necessary orthodontics	0%	X	



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator		91.2%91.7%	88.1%88.9%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$3,350	\$3,350
Family Out-of-pocket maximum		\$6,700	\$6,700
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
	Other practitioner office visit	\$15		\$15	
	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$15		\$15	
	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
Drugs to treat illness or condition	Tier 1	\$5		\$5	
	Tier 2	\$15		\$15	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$100	
	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency room Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	10%		No charge	
	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatient physician fee	10%		No charge	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation services	\$15		\$15	
	Outpatient Habilitation services	\$15		\$15	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Restorative Procedures	Not Covered		Not Covered	
Child Dental Major Services	Periodontal Maintenance Services				
	Crowns and Casts			Not Covered	
	Endodontics			Not Covered	
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics			Not Covered	
Child Orthodontics	Oral Surgery			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

2018/2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: ~~June 15, 2017~~ January 18, 2018

Summary of Benefits and Coverage

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

		Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator		81.8%	78.4% 78.1%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$8,000\$7,200	\$8,000\$7,200
Family Out-of-pocket maximum		\$12,000\$14,400	\$12,000\$14,400
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$25\$30		\$25\$30	
	Other practitioner office visit	\$25\$30		\$25\$30	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
Drugs to treat illness or condition	Tier 1	\$15		\$15	
	Tier 2	\$55		\$55	
	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		\$300	
	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$325		\$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$25\$30		\$25\$30	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$25\$30		\$25\$30	
	Mental/Behavioral health other outpatient items and services	\$25\$30		\$25\$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	20%		No charge	
	Substance Use disorder outpatient office visits	\$25\$30		\$25\$30	
	Substance Use disorder other outpatient items and services	\$25\$30		\$25\$30	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician fee	20%		No charge	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	\$600 per day up to 5 days	
		Professional	20%	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	20%		\$30	
	Outpatient Rehabilitation services	\$25\$30		\$25\$30	
	Outpatient Habilitation services	\$25\$30		\$25\$30	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Restorative Procedures	Not Covered		Not Covered	
Child Dental Major Services	Periodontal Maintenance Services				
	Crowns and Casts			Not Covered	
	Endodontics			Not Covered	
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics			Not Covered	
Child Orthodontics	Oral Surgery			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017/January 18, 2018

Summary of Benefits and Coverage

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

	Individual
	Silver Plan
Actuarial Value - AV Calculator	71.9%/71.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated individual deductible	N/A
Integrated family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500/ \$430/ \$200 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ \$260/ \$400 / \$0
Individual Out-of-pocket maximum	\$7,000/ \$7,550
Family Out-of-pocket maximum	\$14,000/ \$15,100
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$35/\$40		
	Other practitioner office visit	\$35/\$40		
	Specialist visit	\$75/\$80		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$75		
	Imaging (CT/PET scans, MRIs)	\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$55	Pharmacy deductible	
	Tier 3	\$80/\$90	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency room Medical transportation (including emergency and non-emergency)	\$250	X	
	Urgent care	\$35/\$40		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$35/\$40		
	Mental/Behavioral health other outpatient items and services	\$35/\$40		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$35/\$40		
	Substance Use disorder other outpatient items and services	\$35/\$40		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$45		
	Outpatient Rehabilitation services	\$35/\$40		
	Outpatient Habilitation services	\$35/\$40		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth	Not Covered		
	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed			
	Restorative Procedures	Not Covered		
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)	Not Covered		
	Prosthodontics			
Child Orthodontics	Oral Surgery			
	Medically necessary orthodontics	Not Covered		

2018-2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: ~~June 15, 2017~~ January 18, 2018

Summary of Benefits and Coverage

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

	CCSB	CCSB
	Silver Coinsurance Plan	Silver Copay Plan
Actuarial Value - AV Calculator	71.9%	71.4%/71.6%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$125\$200 / \$0	\$2,000 / \$125\$200 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$250\$400 / \$0	\$4,000 / \$250\$400 / \$0
Individual Out-of-pocket maximum	\$7,000\$7,550	\$7,000\$7,550
Family Out-of-pocket maximum	\$14,000\$15,100	\$14,000\$15,100
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45		\$45		
	Other practitioner office visit	\$45		\$45		
	Specialist visit	\$75 \$80		\$75 \$80		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$40		\$40		
	X-rays and Diagnostic Imaging	\$70 \$75		\$70 \$75		
	Imaging (CT/PET scans, MRIs)	20%		\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	\$15	Pharmacy deductible	
	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible	
	Tier 3	\$85	Pharmacy deductible	\$85	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%		
	Physician/surgeon fees	20%		20%		
	Outpatient visit	20%		20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		\$350		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Emergency medical transportation (including emergency and non-emergency)	\$250	X	\$250	X	
	Urgent care	\$45		\$45		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%	X	20%	X	
Mental health, behavioral health, or substance abuse needs	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%	X	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	20%	X	
	Substance Use disorder outpatient office visits	\$45		\$45		
	Substance Use disorder other outpatient items and services	\$45		\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	20%	X	
	Substance use disorder inpatient physician fee	20%	X	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	20%		\$45		
	Outpatient Rehabilitation services	\$45		\$45		
	Outpatient Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
Child eye care	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
Child Dental Basic Services	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Major Services	Restorative Procedures	Not Covered		Not Covered		
	Periodontal Maintenance Services					
Child Dental Orthodontics	Crowns and Casts			Not Covered		
	Endodontics			Not Covered		
	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics			Not Covered		
Child Orthodontics	Oral Surgery			Not Covered		
	Medically necessary orthodontics	Not Covered		Not Covered		

2018-2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017/January 18, 2018

Summary of Benefits and Coverage

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

	CCSB
	Silver HDHP Plan
Actuarial Value - AV Calculator	71.7% / 70.5%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	\$2,000 / \$2,500 integrated
Integrated Family deductible	\$4,000 / \$5,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out-of-pocket maximum	\$6,550 / \$6,650
Family Out-of-pocket maximum	\$13,100 / \$13,300
HSA plan: Self-only coverage deductible	\$2,000 / \$2,500
HSA family plan: Individual deductible	\$2,700

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	20%	X	
	Other practitioner office visit	20%	X	
	Specialist visit	20%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	20%	X	
	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Tier 1	20% up to \$250 per script	X	
	Tier 2	20% up to \$250 per script	X	
	Tier 3	20% up to \$250 per script	X	
	Tier 4	20% up to \$250 per script	X	
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%	X	
	Outpatient visit	20%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X	
	Emergency room physician fee (waived if admitted)	0%	X	
	Emergency room Medical transportation (including emergency and non-emergency)	20%	X	
	Urgent care	20%	X	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	20%	X	
	Mental/Behavioral health other outpatient items and services	20%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	20%	X	
	Substance Use disorder other outpatient items and services	20%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	20%	X	
	Outpatient Rehabilitation services	20%	X	
	Outpatient Habilitation services	20%	X	
	Skilled nursing care	20%	X	
	Durable medical equipment	20%	X	
Child eye care	Hospice service	0%	X	
	Eye exam	No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Child Dental Diagnostic and Preventive	Oral Exam	Not Covered	
Preventive - Cleaning				
Preventive - X-ray				
Sealants per Tooth				
Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed	Not Covered		
	Restorative Procedures			
Child Dental Major Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
Child Orthodontics	Oral Surgery	Not Covered		
	Medically necessary orthodontics			

2018/2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: ~~June 15, 2017~~ January 18, 2018

Summary of Benefits and Coverage

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

	Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	93.9% 94.2%	88.0% 87.9%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated individual deductible	N/A	N/A
Integrated family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0 / \$0	\$650 / \$50 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0 / \$0	\$1,300 / \$100 / \$0
Individual Out-of-pocket maximum	\$1,000	\$2,450 \$2,600
Family Out-of-pocket maximum	\$2,000	\$4,900 \$5,200
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$40 \$15		
	Other practitioner office visit	\$5		\$40 \$15		
	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$8		\$15		
	X-rays and Diagnostic Imaging	\$8		\$25 \$30		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
Drugs to treat illness or condition	Tier 1	\$3		\$5		
	Tier 2	\$10		\$20	Pharmacy deductible	
	Tier 3	\$15		\$35	Pharmacy deductible	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		15%		
	Physician/surgeon fees	10%		15%		
	Outpatient visit	10%		15%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$50		\$100		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Emergency medical transportation (including emergency and non-emergency)	\$30	X	\$75	X	
	Urgent care	\$5		\$40 \$15		
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X	
	Physician/surgeon fee	10%	X	15%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$5		\$40 \$15		
	Mental/Behavioral health other outpatient items and services	\$5		\$40 \$15		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	X	15%	X	
	Mental/Behavioral health inpatient physician fee	10%	X	15%	X	
	Substance Use disorder outpatient office visits	\$5		\$40 \$15		
	Substance Use disorder other outpatient items and services	\$5		\$40 \$15		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	X	15%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$3		\$15		
	Outpatient Rehabilitation services	\$5		\$40 \$15		
	Outpatient Habilitation services	\$5		\$40 \$15		
	Skilled nursing care	10%	X	15%	X	
	Durable medical equipment	10%		15%		
Child eye care	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	Not Covered		Not Covered		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts					
	Endodontics					
	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
Child Orthodontics	Oral Surgery					
	Medically necessary orthodontics	Not Covered		Not Covered		

2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017 / January 18, 2018

Summary of Benefits and Coverage

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

		Silver Plan 200%-250% FPL		
Actuarial Value - AV Calculator		73.9%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		
Integrated Family deductible		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$2,200 / \$430 / \$175 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$4,400 / \$260 / \$350 / \$0		
Individual Out-of-pocket maximum		\$5,850 / \$6,300		
Family Out-of-pocket maximum		\$11,700 / \$12,600		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$30/\$35		
	Other practitioner office visit	\$30/\$35		
	Specialist visit	\$75		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$75		
	Imaging (CT/PET scans, MRIs)	\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$50	Pharmacy deductible	
	Tier 3	\$75	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation (including emergency and non-emergency)	\$250	X	
	Urgent care	\$30/\$35		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$30/\$35		
	Mental/Behavioral health other outpatient items and services	\$30/\$35		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$30/\$35		
	Substance Use disorder other outpatient items and services	\$30/\$35		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$40		
	Outpatient Rehabilitation services	\$30/\$35		
	Outpatient Habilitation services	\$30/\$35		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
Child eye care	Hospice service	No charge		
	Eye exam	No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth	Not Covered		
Child Dental Basic Services	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Major Services	Restorative Procedures	Not Covered		
	Periodontal Maintenance Services			
Child Orthodontics	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)	Not Covered		
Child Orthodontics	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics	Not Covered		

2018-2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: ~~June 15, 2017~~ January 18, 2018

Summary of Benefits and Coverage

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

		Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator		60.8% 60.9%	61.4% 61.6%
Plan design includes a deductible?		Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible		N/A	\$4,800/\$6,000 integrated
Integrated Family deductible		N/A	\$9,600/\$12,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,300 / \$500 / \$0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,600 / \$1,000 / \$0	N/A
Individual Out-of-pocket maximum		\$7,000\$7,550	\$6,560\$6,650
Family Out-of-pocket maximum		\$14,000\$15,100	\$13,100\$13,300
HSA plan: Self-only coverage deductible		N/A	\$4,800
HSA family plan: Individual deductible		N/A	\$4,800

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	X	
	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	X	
	Specialist visit	\$105	After 1st three non-preventive visits	40%	X	
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$40		40%	X	
	X-rays and Diagnostic Imaging	100%	X	40%	X	
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
Drugs to treat illness or condition	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
Outpatient services	Surgery facility fee (e.g., ASC)	100%	X	40%	X	
	Physician/surgeon fees	100%	X	40%	X	
	Outpatient visit	100%	X	40%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	100%	X	40%	X	
	Emergency room physician fee (waived if admitted)	No charge		0%	X	
	Emergency room Medical transportation (including emergency and non-emergency)	100%	X	40%	X	
	Urgent care	\$75	After 1st three non-preventive visits	40%	X	
Hospital stay	Facility fee (e.g. hospital room)	100%	X	40%	X	
	Physician/surgeon fee	100%	X	40%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health other outpatient items and services	\$75	X	40%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	X	
	Mental/Behavioral health inpatient physician fee	100%	X	40%	X	
	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Substance Use disorder other outpatient items and services	\$75	X	40%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X	
	Substance use disorder inpatient physician fee	100%	X	40%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care (cost share per visit)	100%	X	40%	X	
	Outpatient Rehabilitation services	\$75		40%	X	
	Outpatient Habilitation services	\$75		40%	X	
	Skilled nursing care	100%	X	40%	X	
	Durable medical equipment	100%	X	40%	X	
	Hospice service	No charge		0%	X	
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam	Not Covered		Not Covered		
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	Not Covered		Not Covered		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts	Not Covered		Not Covered		
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
Oral Surgery						
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		

2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017 January 18, 2018

Summary of Benefits and Coverage

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

		Catastrophic Plan		
Actuarial Value - AV Calculator				
Plan design includes a deductible?		Yes, integrated		
Integrated individual deductible		\$7,350/\$7,900 integrated		
Integrated Family deductible		\$14,700/\$15,800 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$7,350/\$7,900		
Family Out-of-pocket maximum		\$14,700/\$15,800		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits	
	Other practitioner office visit	0%	After 1st three non-preventive visits	
	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	0%	X	
	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
Drugs to treat illness or condition	Tier 1	0%	X	
	Tier 2	0%	X	
	Tier 3	0%	X	
	Tier 4	0%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X	
	Physician/surgeon fees	0%	X	
	Outpatient visit	0%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation (including emergency and non-emergency)	0%	X	
	Urgent care	0%	After 1st three non-preventive visits	
Hospital stay	Facility fee (e.g. hospital room)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health, behavioral health, or substance abuse needs	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%	X	
	Mental/Behavioral health inpatient physician fee	0%	X	
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits	
	Substance Use disorder other outpatient items and services	0%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care (cost share per visit)	0%	X	
	Outpatient Rehabilitation services	0%	X	
	Outpatient Habilitation services	0%	X	
	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
Child eye care	Hospice service	0%	X	
	Eye exam	No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X	
	Oral Exam	Not Covered		
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed	Not Covered		
	Restorative Procedures			
Child Dental Major Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
Child Orthodontics	Oral Surgery	Not Covered		
	Medically necessary orthodontics			

Endnotes to Covered California ~~2018-2019~~ Patient-Centered Benefit Plan Designs

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

Notes:

- 1) 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. In-network 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 \$2,700 for Plan Year ~~2018XXXX~~. 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 [2017-2019](#) Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder

conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
2	3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or 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.