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

Final Proposed Board-approved

June 15, 2017<sup>2</sup> January 18, 2018

<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

<sup>&</sup>lt;sup>3</sup> 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





Summary of Benefits and Coverage		Platinum		Platinum		
	Member Cost Share amounts describe the Enrollee's out of pocket costs.  Actuarial Value - AV Calculator		e Plan	Copay P 88.1%88	lan	
	e - AV Galculator cludes a deductible?	<del>91.2%</del> <u>91</u> No	.1%	88.1% <u>88</u> No	.9%	
Integrated In	dividual deductible mily deductible	\$0 \$0		\$0 \$0		
Individual de	ductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 / \$0		
	ctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$0 / \$0 / \$0 \$3,350		\$0 / \$0 / \$3,35		
Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		\$6,700 N/A	0	\$6,700 N/A	0	
HSA family plan: Individual deductible		N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$15		\$15		
Health care provider's office or clinic visit	Other practitioner office visit	\$15		\$15		
	Specialist visit	\$30		\$30		
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$15		No charge \$15		
Tests	X-rays and Diagnostic Imaging	\$30		\$30		
	Imaging (CT/PET scans, MRIs)	10%		\$75		
	Tier 1	\$5		\$5		
Drugs to treat illness or	Tier 2	\$15		\$15		
condition	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) Physician/surgeon fees	10% 10%		\$100 \$25		
services	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$150		\$150		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate	Emergency mMedical transportation (including emergency and non- emergency)	\$150		\$150		
attention	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/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 health, behavioral	Mental/Behavioral health inpatient physician fee	10%		No charge		
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$15		\$15		
	Substance Use disorder other outpatient items and services	\$15		\$15		
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days		
	Substance use disorder inpatient physician fee	10%		No charge		
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital services Professional	10% 10%		\$250 per day up to 5 days No charge		
	Home health care (cost share per visit) Outpatient Rehabilitation services	10% \$15		\$20 \$15		
Help recovering or	Outpatient Renabilitation services Outpatient Habilitation services	\$15 \$15		\$15		
other special health needs	Skilled nursing care	10%		\$150 per day up to 5 days		
	Durable medical equipment Hospice service	10% No charge		10% No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	No charge		No charge		
Child Dental	Preventive - Cleaning					
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge		No charge		
Child Dental	Space Maintainers - Fixed  Restorative Procedures			See <del>2018</del> 2019		
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule		
Child Dental	Crowns and Casts Endodontics			See <del>2018</del> 2019		
Major	Periodontics (other than maintenance)	50%		Dental Copay		
Services	Prosthodontics Oral Surgery			Schedule		
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.  Actuarial Value - AV Calculator				l ce Plan 6	Gold Copay Plan 78.4%78.1%	
Plan design inc	cludes a deductible?		No		No	
	dividual deductible mily deductible		\$0 \$0		\$0 \$0	
Individual ded	\$0 / \$0 / \$0		\$0 / \$0 /			
	tible, NOT integrated: Medi of–pocket maximum	cal / Pharmacy / Dental	\$0 / \$0 / \$ <del>6,000</del> \$7		\$0 / \$0 / \$6,000\$7	
Family Out-of-p	oocket maximum		\$12,000 <u>\$1</u> N/A	4,400	<del>\$12,000</del> <u>\$1</u>	
HSA plan: Self-only coverage deductible HSA family plan: Individual deductible					N/A	
Common Medical Event	Se	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	njury, illness, or condition	<del>\$25</del> <u>\$30</u>		<del>\$25</del> <u>\$30</u>	
Health care provider's office or clinic visit	rovider's Other practitioner office visit		\$ <del>2</del> 5 <u>\$30</u>		\$ <del>25</del> \$30	
			\$55		\$55	
	Preventive care/ screening/ i	mmunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imagir	q	\$35 \$55		\$35 \$55	
	Imaging (CT/PET scans, MR		20%		\$275	
	Tier 1		\$15		\$15	
Drugs to treat	Tier 2		\$55		\$55	
condition	Tier 3		\$75		\$75	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC	5)	20%		\$300	
services	Physician/surgeon fees Outpatient visit		20% 20%		\$40 20%	
	·	waived if admitted)				
	Emergency room facility fee (	waived ii admilled)	\$325		\$325	
	Emergency room physician for		No charge		No charge	
	Emergency mMedical transponency)	ortation (including emergency and non-	\$250		\$250	
	Urgent care		\$25 <u>\$30</u>		\$25 <u>\$30</u>	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health out	patient office visits	<del>\$25</del> \$30		<del>\$25</del> \$30	
	Mental/Behavioral health other	er outpatient items and services	<del>\$25</del> \$30		<del>\$25</del> \$30	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health, behavioral	Mental/Behavioral health inpa	atient physician fee	20%		to 5 days No charge	
health, or substance	Substance Use disorder outp	ationt office visits	<del>\$25</del> \$30		\$ <del>25</del> \$30	
abuse needs	oubstance ose disorder outp	aucht office visits	<del>\$20</del> \$50		<del>\$20</del> \$50	
	Substance Use disorder othe	r outpatient items and services	<del>\$25</del> <u>\$30</u>		<del>\$25</del> <u>\$30</u>	
	Substance Use inpatient faci	ity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpa	ient physician fee	20%		No charge	
	Prenatal care and preconcep		No charge		No charge	
	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days No charge	
	Home health care (cost share		20%		\$30	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$25\$30 \$25\$30		\$25\$30 \$25\$30	
recovering or	Skilled nursing care		20%		\$300 per day up	
health needs	Durable medical equipment		20%		to 5 days 20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
		contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		No charge		No charge	
	Sealants per Tooth Topical Fluoride Application		Ĭ			
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		20%		See 20182019 Dental Copay	
	Periodontal Maintenance Ser	vices	20%		Dental Copay Schedule	
	Crowns and Casts					
Child Dental	Endodontics		=00/		See 20182019	
Sarvicas	Periodontics (other than mair	itenance)	50%		Dental Copay Schedule	
	Prosthodontics					
	Oral Surgery					

Plan design in	hare amounts describe the Enrollee's out of pocket costs.	Silver Plan	1
Plan design in	e - AV Calculator	<del>71.9%</del> 71.89	
	dividual deductible	Yes, Medical/Pha N/A	armacy
	ımily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$2,500/ <del>\$130</del> \$20	nn / \$n
Family deduc	ctible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ <del>\$260</del> <u>\$40</u>	00 / \$0
	-of-pocket maximum pocket maximum	\$7,000 <u>\$7,55</u> \$14,000 <u>\$15,</u> 1	
HSA plan: Self	-only coverage deductible	N/A	
HSA family pla	n: Individual deductible	N/A	
Common			Deductibl
Medical Event	Service Type	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	<del>\$35</del> <u>\$40</u>	
Health care provider's office or clinic	Other practitioner office visit	<del>\$35</del> <u>\$40</u>	
visit	Specialist visit	<del>\$75</del> <u>\$80</u>	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$75	
resis	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharmac deductibl
Drugs to treat	Tier 2	\$55	Pharmac
liness or condition	Tier 3	\$80	Pharmac
		20% up to \$250 per	deductible
	Tier 4	script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees Outpatient visit	20% 20%	
	Emergency room facility fee (waived if admitted)	\$350	
Need mmediate	Emergency momentum physician fee (waived if admitted)  Emergency mMedical transportation (including emergency and non-	No charge \$250	Х
immediate attention	emergency)		
	Urgent care	<del>\$35</del> <u>\$40</u>	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
	Physician/surgeon fee	20%	X
	Mental/Behavioral health outpatient office visits	<del>\$35</del> <u>\$40</u>	
	Mental/Behavioral health other outpatient items and services	<del>\$35</del> <u>\$40</u>	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X
Mental health,			
pehavioral nealth, or	Mental/Behavioral health inpatient physician fee	20%	×
substance abuse needs	Substance Use disorder outpatient office visits	<del>\$35</del> <u>\$40</u>	
	Substance Use disorder other outpatient items and services	<del>\$35</del> <u>\$40</u>	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient physician fee	20%	×
	Prenatal care and preconception visits	No charge	
		3	
Pregnancy	Delivery and all inpatient Hospital	20%	Х
Pregnancy	services Professional	20%	X
	services Professional Home health care (cost share per visit)	20% \$45	
Help	services Professional	20%	
Help recovering or other special	services Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services	20% \$45 \$35 <u>\$40</u>	
Help recovering or other special	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment	20% \$45 \$35\$40 \$35\$40 20%	X
Help recovering or other special	services Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care	20% \$45 \$35 <u>\$40</u> \$35 <u>\$40</u> 20%	X
Help recovering or other special nealth needs	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	20% \$45 \$35\$40 \$35\$40 20% 20% No charge	X
Help recovering or other special nealth needs Child eye care	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	20% \$45 \$35\$40 \$35\$40 20% No charge No charge	X
Help recovering or other special nealth needs Child eye care	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care  Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	20% \$45 \$35\$40 \$35\$40 20% 20% No charge No charge	X
Help recovering or recovering or other special nealth needs Child eye care Child Dental Diagnostic and	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care  Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning	20% \$45 \$35\$40 \$35\$40 20% No charge No charge	X
Help recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care  Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Varay Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	20% \$45 \$35\$40 \$35\$40 20% 20% No charge No charge	X
Help recovering or recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	20% \$45 \$35\$40 \$35\$40 20% 20% No charge No charge	X
Help recovering or recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care  Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Vray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Restorative Procedures Periodontal Maintenance Services	20% \$45 \$35\$40 \$35\$40 20% 20% No charge No charge	X
Help recovering or recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care  Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Restorative Procedures	20% \$45 \$35\$40 \$35\$40 20% 20% No charge No charge	X
Help recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services  Skilled nursing care  Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services Crowns and Casts	20% \$45 \$35\$40 \$35\$40 20% 20% No charge No charge	X
Help recovering or other special nealth needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major	services Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)	20% \$45 \$36\$40 \$35\$40 20%  No charge No charge No charge	X
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major Services	services Professional  Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services  Skilled nursing care  Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	20% \$45 \$36\$40 \$35\$40 20%  No charge No charge No charge	X

Summary of		The state of the s					
	f Benefits and Coverage		CCSB Silver		CCSB		
Member Cost S	nber Cost Share amounts describe the Enrollee's out of pocket costs.			Plan	Silver Copay Plan		
Actuarial Value	e - AV Calculator		71.9%		<del>71.4%</del> 71.69		
	cludes a deductible?		Yes, Medical/Pha	armacy	Yes, Medical/Pharmacy		
	idividual deductible amily deductible		N/A N/A		N/A N/A		
Individual de	eductible, NOT integrated: Medica		\$2,000 / <del>\$125</del> <u>\$2</u>		\$2,000 / <del>\$125</del> <u>\$2</u>		
	ctible, NOT integrated: Medical /	Pharmacy / Dental	\$4,000 / <del>\$250</del> \$4 <u>1</u> \$7,000\$7,55		\$4,000 / \$250 <u>\$4</u> \$7,000\$7,55		
Family Out-of-	-pocket maximum		<del>\$14,000</del> \$15,1		\$14,000 <u>\$15,</u> 1		
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A		
Common Medical Event	Sonio	е Туре	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Medical Event	Servic	у туре	Member Cost Share	Applies	Member Gost Share	Applies	
	Primary care visit to treat an injury	, illness, or condition	\$45		\$45		
Health care							
provider's	Other practitioner office visit		\$45		\$45		
office or clinic visit							
	Specialist visit		\$ <del>75</del> <u>\$80</u>		<del>\$75</del> \$80		
	Preventive care/ screening/ immu	nization	No charge		No charge		
	Laboratory Tests	iization	\$40		\$40		
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$70\$75 20%		\$ <del>70</del> \$75 \$300		
	, , , , , , , , , , , , , , , , , , ,			Pharmacy		Pharmacy	
	Tier 1		\$15	deductible	\$15	deductible	
	-			Pharmacy		Pharmacy	
Drugs to treat	Tier 2		\$55	deductible	\$55	deductible	
illness or condition	Tion 2		005	Pharmacy	005	Pharmacy	
	Tier 3		\$85	deductible	\$85	deductible	
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy	20% up to \$250 per script after pharmacy	Pharmacy	
			deductible	deductible	deductible	deductible	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%		20%		
services	Outpatient visit		20%		20%		
	Emergency room facility fee (waiv	ed if admitted)	\$350		\$350		
	Emergency room physician fee (w	vaived if admitted)	No charge		No charge		
Need	Emergency mMedical transportation	·	-	v		.,	
immediate attention	emergency)		\$250	Х	\$250	Х	
atterition							
	Urgent care		\$45		\$45		
Hospital stay	Facility fee (e.g. hospital room)		20%	Х	20%	Х	
	Physician/surgeon fee		20%	X	20%	×	
	Mental/Behavioral health outpatie	nt office visits	\$45		\$45		
	Mental/Behavioral health other ou	tratiant items and convises	0.45		¢45		
	ivientai/benavioral nealth other ou	tpatient items and services	\$45		\$45		
	Mental/Behavioral health inpatient	facility fee (e.g.hospital room)	20%	Х	20%	Х	
Mental health,	Mental/Behavioral health inpatient				2070		
behavioral health, or	Menta/Denavioral nealth inpatient		200/				
substance		physician fee	20%	X	20%	×	
abuse needs	Substance Use disorder outpatien				20%		
Loude needs	Substance Use disorder outpatier		20% \$45				
		nt office visits	\$45		20% \$45		
and the training the training training to the training tr	Substance Use disorder outpatier Substance Use disorder other out	nt office visits			20%		
asuos neeus	Substance Use disorder other out	nt office visits	\$45 \$45	X	20% \$45 \$45	X	
and the state of t		nt office visits	\$45		20% \$45		
Laure Heeus	Substance Use disorder other out	patient items and services e (e.g. hospital room)	\$45 \$45	X	20% \$45 \$45	X	
- Julia Heeds	Substance Use disorder other out	patient items and services le (e.g. hospital room) physician fee	\$45 \$45 20%	x	20% \$45 \$45 20%	x	
Pregnancy	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services	patient items and services e (e.g. hospital room) physician fee visits	\$45 \$45 20% 20% No charge 20%	x x x	20% \$45 \$45 20% 20% No charge 20%	x x x	
	Substance Use disorder other out  Substance Use inpatient facility fe  Substance use disorder inpatient  Prenatal care and preconception  Delivery and all inpatient services	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional	\$45 \$45 20% 20% No charge	x x x	20% \$45 \$45 20% 20% No charge 20%	X X X	
Pregnancy	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services Home health care (cost share per Outpatient Rehabilitation services	patient items and services  e (e.g. hospital room)  physician fee  visits  espital  ofessional  visit)	\$45  \$45  20%  20%  No charge  20%  20%  20%  \$45	x x x	20% \$45 \$45 20% 20% No charge 20% 20% \$45 \$45	x x x	
Pregnancy Help recovering or	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of the prenatal care and preconception of prenatal care and prenata	patient items and services  e (e.g. hospital room)  physician fee  visits  espital  ofessional  visit)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45	X X X	20% \$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45	X X X	
Pregnancy	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services Home health care (cost share per Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care	patient items and services  e (e.g. hospital room)  physician fee  visits  espital  ofessional  visit)	\$45  20%  20%  No charge  20%  20%  \$45  \$45  \$45  20%	x x x	20% \$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$45	x x x	
Pregnancy Help recovering or other special	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of the prenatal care and preconception of prenatal care and prenata	patient items and services  e (e.g. hospital room)  physician fee  visits  espital  ofessional  visit)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45	X X X	20% \$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45	X X X	
Pregnancy Help recovering or other special health needs	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services Home health care (cost share per Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45  \$45  20%  20%	X X X	20% \$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$20% \$45 \$45 \$20%	X X X	
Pregnancy Help recovering or other special	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services Home health care (cost share per Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam  1 pair of glasses per year (or contains)	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45  \$45  \$0%  No charge	X X X	20% \$45  \$45  20%  No charge  20%  \$45  \$45  \$45  \$45  \$A5  No charge	X X X	
Pregnancy Help recovering or other special health needs	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services Home health care (cost share per Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45  \$40  20%  No charge  No charge	X X X	20% \$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$45  \$45  \$A5  No charge  No charge	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of prenatal care prena	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45  \$40  20%  No charge  No charge	X X X	20% \$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$45  \$45  \$A5  No charge  No charge	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of periodic present in the prenatal care and preconception of present in the present in the prenatal care and preconception of present in the	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)	\$45  20%  20%  No charge  20%  20%  \$45  \$45  \$20%  No charge No charge No charge	X X X	20% \$45  \$45  20%  No charge 20% \$45 \$45 \$45 \$20%  No charge No charge No charge	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of Delivery and all inpatient services Home health care (cost share per Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contained of the preventive - X-ray Sealants per Tooth	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)	\$45  20%  20%  No charge  20%  20%  \$45  \$45  \$20%  No charge No charge No charge	X X X	20% \$45  \$45  20%  No charge 20% \$45 \$45 \$45 \$20%  No charge No charge No charge	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of periodic present in the prenatal care and preconception of present in the present in the prenatal care and preconception of present in the	patient items and services  e (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)	\$45  20%  20%  No charge  20%  20%  \$45  \$45  \$20%  No charge No charge No charge	X X X	20% \$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$45  \$45  \$45  No charge  No charge  No charge  No charge	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of periodic present in the prenatal care and preconception of periodic present in the prenatal care and preconception of periodic present in the prenatal care and preconception of prenatal care and previous outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contained preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services	patient items and services  pet (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)  act lenses in lieu of glasses)	\$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$20%  No charge  No charge  No charge  No charge	X X X	20% \$45  \$45  20%  No charge 20% \$45 \$45 \$45 \$20%  20%  No charge No charge No charge	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services Home health care (cost share per Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or conta Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	patient items and services  pet (e.g. hospital room)  physician fee  visits  spital  ofessional  visit)  act lenses in lieu of glasses)	\$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$20%  No charge  No charge  No charge  No charge	X X X	20% \$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$45  \$45  \$45  No charge  No charge  No charge  No charge	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception Delivery and all inpatient services Produpatient Rehabilitation services Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or conta Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts	patient items and services  patient items and services  pe (e.g. hospital room)  physician fee  visits  papital  ofessional  visit)  act lenses in lieu of glasses)	\$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$20%  No charge  No charge  No charge  No charge	X X X	20% \$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$20% 20% No charge No charge No charge No charge See 20182019 Dental Copay Schedule	X X X	
Pregnancy  Help recovering or other special health needs  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of prenatal care per Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contained or preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintena)	patient items and services  patient items and services  pe (e.g. hospital room)  physician fee  visits  papital  ofessional  visit)  act lenses in lieu of glasses)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45  20%  No charge  No charge  No charge  No charge	X X X	20% \$45  \$45  20%  20%  No charge  20%  \$45  \$45  \$45  \$45  \$45  \$45  No charge  No charge  No charge  No charge  See 20182019 Dental Copay Schedule	X X X	
Pregnancy  Help recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major	Substance Use disorder other out Substance Use inpatient facility fe Substance use disorder inpatient Prenatal care and preconception of periodic present in the prenatal care and preconception of periodic present in the prenatal care and preconception of periodic present in the prenatal care and preconception of periodic present in the prenatal care and preventes Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contate preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	patient items and services  patient items and services  pe (e.g. hospital room)  physician fee  visits  papital  ofessional  visit)  act lenses in lieu of glasses)	\$45  \$45  20%  20%  No charge  20%  20%  \$45  \$45  20%  No charge  No charge  No charge  No charge	X X X	20% \$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$20% 20% No charge No charge No charge No charge See 20182019 Dental Copay Schedule	X X X	

	Panafita and Cavarage	<u> </u>	0000	
•	Benefits and Coverage		CCSB Silver	
	hare amounts describe the En	rollee's out of pocket costs.	HDHP PI	an
	- AV Calculator		<del>71.7%</del> <u>70.</u>	_
	cludes a deductible? dividual deductible		Yes, integr \$2,000\$2,500 in	
	mily deductible ductible, NOT integrated: Me	odical / Pharmacy / Dontal	\$4,000 <u>\$5,000</u> ii N/A	ntegrated
Family deduc	tible, NOT integrated: Medic		N/A	
	-of-pocket maximum pocket maximum		\$6,550 <u>\$6,</u> \$13,100 <u>\$13</u>	
HSA plan: Self-	only coverage deductible n: Individual deductible		\$ <del>2,000</del> \$2, \$2,700	<u>500</u>
noA faililly pla	n. marviduai deductible		\$2,700	
Common				
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an i	njury, illness, or condition	20%	х
Health care provider's office or clinic	Other practitioner office visit		20%	х
visit	Specialist visit		20%	Х
	Preventive care/ screening/ ir	nmunization	No charge	
	Laboratory Tests		20%	Х
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI:		20%	X
	Tier 1		20% up to \$250 per script	Х
Drugs to treat	Tier 2	20% up to \$250 per script	Х	
illness or condition	Tier 3		20% up to \$250 per script	Х
	Tier 4		20% up to \$250 per	X
	Surgery facility fee (e.g., ASC	)	script 20%	X
Outpatient services	Physician/surgeon fees	,	20%	Х
	Outpatient visit	20%	X	
	Emergency room facility fee (	waived if admitted)	20%	Х
	Emergency room physician fe	0%	Х	
Need mmediate attention	Emergency mMedical transpo emergency)	ortation (including emergency and non-	20%	Х
	Urgent care		20%	х
	Facility fee (e.g. hospital room	1)	20%	Х
Hospital stay	Physician/surgeon fee	,	20%	X
	Mental/Behavioral health outp	patient office visits	20%	х
	Mental/Behavioral health othe	er outpatient items and services	20%	Х
	Mental/Behavioral health inna	tient facility fee (e.g.hospital room)	20%	Х
Mental health,				
behavioral nealth, or	Mental/Behavioral health inpa	itient physician fee	20%	Х
substance abuse needs	Substance Use disorder outp	atient office visits	20%	Х
	Substance Use disorder othe	r outpatient items and services	20%	х
	Substance Use inpatient facili	ity fee (e.g. hospital room)	20%	X
	Substance use disorder inpat		20%	Х
	Prenatal care and preconcept		No charge	^
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care (cost share	per visit)	20%	X
Help recovering or	Outpatient Rehabilitation service Outpatient Habilitation service		20% 20%	X
other special	Skilled nursing care		20%	Х
nealth needs	Durable medical equipment		20%	X
	Hospice service Eye exam		0% No charge	X
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
	Oral Exam	· ,	<u>~</u>	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		,	
and Preventive	Sealants per Tooth Topical Fluoride Application		No charge	
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		20%	
	Periodontal Maintenance Sen	vices		
Services	Crowns and Casts			
	Endodontics			
Child Dental		tenance)	50%	
Child Dental Major	Endodontics Periodontics (other than main Prosthodontics	tenance)	50%	
Services  Child Dental Major Services  Child	Endodontics Periodontics (other than main	·	50%	

#### 20182019 Patient-Centered Benefit Plan Designs 10.0 EHB Date: <del>June 15, 2017</del><u>January 18, 2018</u>

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.  Actuarial Value - AV Calculator		Silver Plan 100%-150% FPL 93.9%94.2%		Silver Plan 150%-200% FPL 88.0%87.9%			
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy			
	dividual deductible		N/A		N/A		
	mily deductible ductible, NOT integrated: Mo	edical / Pharmacy / Dental	N/A \$75 / \$0 / \$0		N/A \$650 / \$50 / \$0		
	tible, NOT integrated: Medic	cal / Pharmacy / Dental	\$150 / \$0		\$1,300 / \$100 /		
amily Out-of-	-of-pocket maximum pocket maximum		\$1,00 \$2,00		\$2,450 <u>\$2,60</u> \$4,900 <u>\$5,20</u>		
	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A		
noA lallilly plai	II. IIIdividuai deductible		IN/A		IN/A		
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies	
	Primary care visit to treat an i	njury, illness, or condition	\$5		\$ <del>10</del> \$15		
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$ <del>10</del> \$15		
	Specialist visit		\$8		\$25		
	Preventive care/ screening/ ir	nmunization	No charge		No charge		
	Laboratory Tests X-rays and Diagnostic Imagin	g	\$8 \$8		\$15 \$25\$30		
	Imaging (CT/PET scans, MRI		\$50		\$100		
	Tier 1		\$3		\$5		
Drugs to treat	Tier 2		\$10		\$20	Pharma deductib	
ondition	Tier 3		\$15		\$35	Pharma deductil	
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharma deductil	
Outpatient	Surgery facility fee (e.g., ASC	)	10%		15%		
services	Physician/surgeon fees Outpatient visit		10% 10%		15% 15%		
	Emergency room facility fee (	vaived if admitted)	\$50		\$100		
		<u>,                                      </u>					
	Emergency room physician fe	<u> </u>	No charge		No charge		
	Emergency mMedical transpo emergency)	rtation <u>(including emergency and non-</u>	\$30	Х	\$75	Х	
	Urgent care		\$5		\$ <del>10</del> \$15		
Hospital stay	Facility fee (e.g. hospital roon	1)	10%	Х	15%	Х	
nospital stay	Physician/surgeon fee		10%	X	15%	×	
	Mental/Behavioral health outp	atient office visits	\$5		\$ <del>10</del> \$15		
	Mental/Behavioral health othe	er outpatient items and services	\$5		\$ <del>10</del> \$15		
	Mental/Behavioral health inna	tient facility fee (e.g.hospital room)	10%	Х	15%	Х	
Mental health,	·						
pehavioral nealth, or	Mental/Behavioral health inpa	tient physician fee	10%	X	15%	X	
substance	Substance Use disorder outp	atient office visits	\$5		\$ <del>10</del> \$15		
	Substance Use disorder othe	r outpatient items and services	\$5		\$ <del>10</del> \$15		
	Substance Use inpatient facili	ty fee (e.g. hospital room)	10%	Х	15%	Х	
	Substance use disorder inpat		10%	X	15%	X	
	Prenatal care and preconcept		No charge	v	No charge		
	Delivery and all inpatient services	Hospital	10%	X	15%	X	
	Home health care (cost share	Professional per visit)	10% \$3	X	15% \$15	X	
deln	Outpatient Rehabilitation serv	ices	\$5		<del>\$10</del> \$15		
recovering or	Outpatient Habilitation service	es	\$5	, :	\$10 <u>\$15</u>		
health needs	Skilled nursing care		10%	Х	15%	Х	
	Durable medical equipment Hospice service		10% No charge		15% No charge		
	Eye exam		No charge		No charge		
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	L	
Child Dental	Oral Exam						
Diagnostic	Preventive - Cleaning Preventive - X-ray		No charge		No charge		
and	Sealants per Tooth		No charge		No charge		
	Topical Fluoride Application Space Maintainers - Fixed						
Child Dental	Restorative Procedures						
Basic Services		viana	20%		20%		
Jei vices	Periodontal Maintenance Ser- Crowns and Casts	rices				_	
Child Dental	Endodontics						
Major	Periodontics (other than main	tenance)	50%		50%		
Services	Prosthodontics Oral Surgery		1				
Child							
	Medically necessary orthodor	At	50%		50%		

### 20182019 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: June 15, 2017 January 18, 2018

thodontics Medically necessary orthodontics

#### Summary of Benefits and Coverage

	hare amounts describe the Ei	nrollee's out of pocket costs.	Silver Plan 200%-250% FF 73.9%	L
	cludes a deductible? dividual deductible		Yes, Medical/Phari N/A	macy
	mily deductible	15-14 Bl	N/A	
	ductible, NOT integrated: M ctible, NOT integrated: Medi		\$2,200 / <del>\$130</del> <u>\$175</u> \$4,400 / <del>\$260</del> <u>\$350</u>	
Individual Out-	-of-pocket maximum		\$5,850 <u>\$6,300</u>	
	pocket maximum -only coverage deductible		\$11,700 <u>\$12,60</u> N/A	<u>0</u>
	n: Individual deductible		N/A	
Common Medical Event	9	Member Cost Share	Deductible Applies	
	Primary care visit to treat an	ervice Type injury, illness, or condition	<del>\$30</del> \$35	7.40
Health care provider's	Other practitioner office visit		\$30\$35	
office or clinic				
	Specialist visit  Preventive care/ screening/ i	mmunization	\$75 No charge	
	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR		\$75 \$300	
	illaging (CT/FET Scans, WIN	15)	φ300	Pharmac
	Tier 1		\$15	deductible
Drugs to treat	Tier 2		\$50	Pharmac deductibl
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., ASC Physician/surgeon fees	C)	20%	
services	Outpatient visit	20%		
	Emergency room facility fee	\$350		
	Emergency room physician f	No charge		
Need		ortation (including emergency and non-	-	.,
immediate attention	emergency)	\$250	Х	
attention	Urgent care		\$ <del>30</del> \$35	
Hospital stay	Facility fee (e.g. hospital room	n)	20%	Х
	Physician/surgeon fee		20%	<del>-X</del>
	Mental/Behavioral health out	<del>\$30</del> \$35		
	Mental/Behavioral health oth	er outpatient items and services	<del>\$30</del> <u>\$35</u>	
	Mental/Behavioral health inp	atient facility fee (e.g.hospital room)	20%	Х
Mental health,	Mental/Behavioral health inp	ationt physician foo	20%	×
behavioral health, or	ivientai/benavioral nealth inp	20%	*	
substance abuse needs	Substance Use disorder outp	\$ <del>30</del> \$35		
	Substance Use disorder other	er outpatient items and services	\$ <del>30</del> \$35	
	Substance Use inpatient faci	lity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpa	tient physician fee	20%	×
	Prenatal care and preconcep	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care (cost share Outpatient Rehabilitation ser		\$40 <del>\$30</del> \$35	
Help recovering or	Outpatient Habilitation service		\$30 <u>\$35</u>	
other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
Child eye care		contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning		. 40 Grange	
Diagnostic	Preventive - X-ray		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		j	
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		20%	
Services	Periodontal Maintenance Ser	vices		
Obilet D	Crowns and Casts Endodontics			
Child Dental Major	Periodontics (other than mail	ntenance)	50%	
Services	Prosthodontics	,		
	Oral Surgery			
Child				

50%

#### 20182019 Patient-Centered Benefit Plan Designs 10.0 EHB Date: <del>June 15, 2017</del><u>January 18, 2018</u>

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	Bronz HDHP P		
Actuarial Value - AV Calculator		60.8%60.9%	6	<del>61.4%</del> <u>61.6%</u>		
	cludes a deductible?	Yes, Medical/Pha	ırmacy	Yes, integ		
Integrated Fa	dividual deductible mily deductible	N/A N/A		\$4,800 <u>\$6,000</u> \$9,600 <u>\$12,000</u>		
	ductible, NOT integrated: Medical / Pharmacy / Dental ctible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 \$12,600 / \$1,00		N/A N/A		
Individual Out-	-of-pocket maximum	<del>\$7,000</del> <u>\$7,55</u>	<u>i0</u>	\$ <del>6,550</del> \$6		
	pocket maximum -only coverage deductible	<del>\$14,000</del> \$ <u>15,1</u> N/A	<u>00</u>	<del>\$13,100<u>\$1</u></del> \$4,80		
HSA family plan: Individual deductible		N/A		\$4,80	0	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
medical Event	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive	40%	Х	
Health care	Other practitioner office visit	\$75	visits  After 1st three non-preventive	40%	Х	
office or clinic visit		\$105	visits  After 1st three non-preventive	40%	Х	
	Preventive care/ screening/ immunization	No charge	visits	No charge	^	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 100%	Х	40% 40%	X	
Tests	Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
condition	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	100% 100%	X	40% 40%	X	
services	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%	х	
Need immediate	Emergency mMedical transportation (including emergency and non-emergency)	100%	X	40%	Х	
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х	
Hospital stay	Facility fee (e.g. hospital room)	100%	Х	40%	Х	
	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,						
behavioral health, or	Mental/Behavioral health inpatient physician fee	100%	X	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%	Х	
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital	100%	Х	40%	х	
	Services Professional	100%	X	40%	X	
Hale	Home health care (cost share per visit) Outpatient Rehabilitation services	100% \$75	X	40% 40%	X	
Help recovering or	Outpatient Habilitation services	\$75		40%	X	
other special health needs	Skilled nursing care	100%	Х	40%	Х	
	Durable medical equipment Hospice service	100% No charge	X	40% 0%	X	
Child	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray	No charge		No charge		
and Preventive	Sealants per Tooth Topical Fluoride Application	90				
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		20%		
Services	Periodontal Maintenance Services Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	50%		50%		
JUI 71088	Prosthodontics Oral Surgery					
Child		500/		F00/		
Orthodontics	Medically necessary orthodontics	50%		50%		

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Catastro	ohic Plan
	- AV Calculator	- Juliusti of	
	cludes a deductible?	Yes, into	egrated
	dividual deductible mily deductible	<del>\$7,350</del> <u>\$7,90</u>	0 integrated
	ductible, NOT integrated: Medical / Pharmacy / Dental	\$14,700 <u>\$15,8</u> N/	
	ctible, NOT integrated: Medical / Pharmacy / Dental	N/ <del>\$7,350</del>	
Family Out-of-	pocket maximum	<del>\$14,700</del>	\$15,800
	-only coverage deductible n: Individual deductible	N/	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st thronon-prevent visits
Health care provider's office or clinic visit	Other practitioner office visit	0%	After 1st thr non-prevent visits
	Specialist visit	0%	Х
	Preventive care/ screening/ immunization Laboratory Tests	No charge 0%	X
Tests	X-rays and Diagnostic Imaging	0%	Х
	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) Physician/surgeon fees	0% 0%	X
services	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate	Emergency mMedical transportation (including emergency and non- emergency)	0%	Х
attention	Urgent care	0%	After 1st thr non-prevent visits
Hospital stay	Facility fee (e.g. hospital room)	0%	Х
	Physician/surgeon fee	0%	X
	Mental/Behavioral health outpatient office visits	0%	After 1st thr non-prevent visits
	Mental/Behavioral health other outpatient items and services	0%	Х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	Х
Mental health, pehavioral	Mental/Behavioral health inpatient physician fee	0%	Х
nealth, or substance abuse needs	Substance Use disorder outpatient office visits	0%	After 1st the
	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 services Hospital	0%	X
	Professional Home health care (cost share per visit)	0% 0%	X
Help	Outpatient Rehabilitation services	0% 0%	X
ecovering or other special	Outpatient Habilitation services Skilled nursing care	0%	X
nealth needs	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	Х
Child Dental	Oral Exam Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application	ondige	
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	х
Services	Periodontal Maintenance Services	0 70	X
	Crowns and Casts Endodontics		X
Child Dental Major	Periodontics (other than maintenance)	0%	X

Prosthodontics Oral Surgery

Medically necessary orthodontics





Member Cost S	Platinum		Platinum		
	hare amounts describe the Enrollee's out of pocket costs.  - AV Calculator	Coinsurance 91.2%91		Copay P 88.1%88	
	cludes a deductible?	No	_	No	_
	dividual deductible mily deductible	\$0 \$0		\$0 \$0	
Individual de	ductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0 \$0 / \$0 / \$0		\$0 / \$0 / \$0 \$0 / \$0 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum		\$3,350	)	\$3,350	)
HSA plan: Self	-only coverage deductible	\$6,700 N/A	)	\$6,700 N/A	)
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's office or clinic visit	Other practitioner office visit	\$15		\$15	
Viole	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$15		No charge \$15	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$30 10%		\$30 \$75	
	. ,				
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15		\$15	
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC) Physician/surgeon fees	10% 10%		\$100 \$25	
Services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate	Emergency mMedical transportation (including emergency and non- emergency)	\$150		\$150	
attention	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/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 health, behavioral	Mental/Behavioral health inpatient physician fee	10%		No charge	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up	
	Substance use disorder inpatient physician fee	10%		to 5 days No charge	
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	10%		\$250 per day up to 5 days	
	services Professional Home health care (cost share per visit)	10%		No charge	
Help	Outpatient Rehabilitation services	10% \$15		\$20 \$15	
recovering or other special	Outpatient Habilitation services Skilled nursing care	\$15 10%		\$15 \$150 per day up	
health needs	Durable medical equipment	10%		to 5 days 10%	
	Hospice service Eye exam	No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child B	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application	0076160		0076160	
Child Dental	Space Maintainers - Fixed				
Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
01.11.1	Crowns and Casts Endodontics			Not Covered Not Covered	
Child Dental Major	Periodontics Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics			Not Covered	
Child	Oral Surgery			Not Covered	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary	of	Benefits	and	Coverag	ıe

	Summary of Benefits and Coverage  Member Cost Share amounts describe the Enrollee's out of pocket costs.		Gold Coinsurance Plan		Gold Copay Plan		
Integrated Franchic Medical Administration   19						<del>78.4%</del> <u>78</u>	.1%
Marchanic   Secretaria   Secr							
Family doubt-black, NOT Integrated: Medical / Pharmacy / Dental   \$9,30 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,000 / 50   \$0,00	Integrated Fa	mily deductible	\$0		\$0		
High plants Self-only coverage deductible   N/A   N/A   N/A	Individual Out-	\$6,000 <u>\$7</u>	<u>,200</u>	\$6,000 <u>\$</u> 7	,200		
Manufact   Permany care visit to treat an injury, illness, or condition   Manufact   M							4,400
Primary care visit to treat an injury, lineas, or condition    Primary care visit to treat an injury, lineas, or condition   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$25530   \$255				N/A		N/A	
Health care providers   Section		Ser	vice Type				Deductible Applies
Proventive care   Specials visit   Spe				<del>\$25</del> <u>\$30</u>		<del>\$25</del> <u>\$30</u>	
Specialist visit  Preventive carea screening/immunization  No charge  Leads  Exclusionation (Prests  X-ray and Diagnostic Imaging  \$55 \$55 \$55 \$55 \$55 \$55 \$55 \$55 \$55 \$5	provider's	Other practitioner office visit		<del>\$25</del> \$30		<del>\$25</del> \$30	
Laboratory Tests		Specialist visit		\$55		\$55	
Test			munization				
Ter 1							
Drugs to treat lineas or condition Ter 3 Ter 4 20% up to \$250 per script Ter 3 Ter 4 20% up to \$250 per script Physician/surgeon fees 20% \$300 per script Physician/surgeon fees 20% \$325 S325 No charge No charge President care President fee (waived if admitted) Delivery and all inpatient fee (waived if admitted) Delivery and all inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% \$600 per day up to 5 days No charge President feelth inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% No charge President feelth inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% No charge President feelth inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% No charge President feelth inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% No charge President feelth inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% No charge President feelth inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% No charge President feelth inpatient facility fee (e.g. hospital room) Physician/surgeon fee 20% No charge President feelth inpatient facility fee (e.g. hospital room) Physician feelth feelth inpatient facility fee (e.g. hospital room) Physician feelth feelth inpatient feelth physician fee 20% No charge Pregnancy Substance Use disorder outpatient files and services Pregnancy Substance Use disorder inpatient physician fee President feelth feelth physician fee President feelth							
Tings to real limites or condition  Tier 3  Tier 4  20% up to \$250 per script  Physician/surgeon fees  Outpatient services  Physician/surgeon fees  Outpatient services  Physician/surgeon fees  Outpatient value  Physician/surgeon fees  Outpatient value  Physician/surgeon fees  Outpatient value  Physician/surgeon fees  Outpatient value  Emergency room facility fee (waived if admitted)  Emergency room physician fee (waived if admitted)  No charge  Emergency room physician fee (waived if admitted)  No charge  Emergency room physician fee (waived if admitted)  No charge  Emergency room physician fee (waived if admitted)  No charge  Facility fee (e.g. hospital room)  Urgent care  Facility fee (e.g. hospital room)  Physician/surgeon fee  Mental/Behavioral health outpatient office visits  S26530  Mental/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Substance  Substance Use disorder outpatient office visits  Substance Use disorder outpatient office visits  Substance Use disorder outpatient facility fee (e.g. hospital room)  Substance Use disorder outpatient facility fee (e.g. hospital room)  Substance Use disorder optient outpatient fee  Pregnancy  Pregnancy  Pregnancy  Pressional  Hopp to 5 days  Substance Use disorder optient facility fee (e.g. hospital room)  Substance Use disorder optient facility fee (e.g. hospital room)  Substance Use disorder optient facility fee (e.g. hospital room)  Substance Use disorder optient facility fee (e.g. hospital room)  Substance Use disorder optient facility fee (e.g. hospital room)  Substance Use disorder optient facility fee (e.g. hospital room)  Substance Use disorder optient facility fee		Tier 1		\$15		\$15	
Tier 4	illness or	Tier 2		\$55		\$55	
Outpatient Surgery facility fee (e.g., ASC)	condition	Tier 3					
Physician/surgeon fees				per script		per script	
Culpatent visit   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%   20%	Outpatient	Physician/surgeon fees		20%		\$40	
Emergency room physician fee (walved if admitted)  No charge  Emergency mMedical transportation (including emergency and non- emergency)  Urgent care  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250		·					
Remainmediate attention   Remainmediate at		Emergency room facility fee (w	raived if admitted)	\$325		\$325	
## standard attention    Comparison   Compar		Emergency room physician fee	(waived if admitted)	No charge		No charge	
Hospital stay  Facility fee (e.g. hospital room)  Physician/surgeon fee  Mental/Behavioral health outpatient office visits  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%  Mental/Behavioral health inpatient physician fee  20%  No charge  Substance Use disorder outpatient office visits  \$25\$30  \$25\$30  \$25\$30  ***Sayo**  No charge  Substance Use disorder outpatient office visits  \$25\$30  \$25\$30  \$25\$30  \$25\$30  \$25\$30  \$25\$30  \$25\$30  \$25\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30  \$26\$30	mmediate		tation (including emergency and non-	\$250		\$250	
Physician/surgeon fee 20% No charge  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% S600 per day up to 5 days No charge  Mental/Behavioral health inpatient physician fee 20% No charge  Substance Use disorder outpatient office visits \$25\$30 \$25\$30  Substance Use disorder outpatient office visits \$25\$30 \$25\$30  Substance Use disorder outpatient items and services \$25\$30 \$25\$30  Substance Use disorder outpatient physician fee 20% No charge  Substance Use inpatient facility fee (e.g. hospital room) 20% \$600 per day up to 5 days  Substance Use inpatient physician fee 20% No charge  Pregnancy Prenatal care and preconception visits No charge No charge  Pregnancy Delivery and all inpatient Hospital 20% \$600 per day up to 5 days  Professional 20% No charge  Help recovering or other special health care (cost share per visit) 20% \$300 Qutpatient Rehabilitation services \$25\$30 \$25\$30 Qutpatient Rehabilitation services \$25\$30 \$25\$30 Qutpatient Habilitation services \$25\$30 \$25\$30 Por day up to 5 days Qutpatient Services \$25\$30 \$25\$30 Qutpatient Habilitation services		Urgent care		\$ <del>25</del> \$30		\$25 <u>\$30</u>	
Mental/Behavioral health outpatient office visits \$25\s30 \$25\	Hospital Stay					to 5 days	
Mental health, behavioral health inpatient facility fee (e.g.hospital room)  Mental/Behavioral health inpatient physician fee  Mental/Behavioral health inpatient physician fee  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)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Prenatel care and preconception visits  No charge  Prenatel care and preconception visits  No charge  President care (cost share per visit)  Outpatient Rehabilitation services  Substance Use inpatient physician fee  Prenatal care and preconception visits  No charge  No charge  No charge  No charge  Professional  Professional  Professional  Dutpatient Habilitation services  Substance Use disorder outpatient items and services  Prenatal care and preconception visits  No charge  No charge  No charge  Salo  Salo  Salo  Salo  Salo  Salo  Salo  No charge  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth		, s	atient office visits				
Mental health, behavioral health inpatient facility lee (e.g. inospital room)  Mental/Behavioral health, or substance abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Hospital  Services  Home health care (cost share per visit)  Outpatient Rehabilitation services  Substance Use inpatient physician fee  Prenatal care and preconception visits  No charge  No charge  No charge  No charge  Solve the hospital  Services  Professional  Outpatient Rehabilitation services  Sezes 30		Mental/Behavioral health other	outpatient items and services	<del>\$25</del> \$30		<del>\$25</del> \$30	
Mental health, behavioral health, behavioral health inpatient physician fee 20% No charge  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 Pregnancy Delivery and all inpatient services Professional 20% No charge \$600 per day up to 5 days  Professional 20% No charge \$600 per day up to 5 days  Professional 20% No charge \$600 per day up to 5 days  Professional 20% No charge \$300  Outpatient Rehabilitation services \$25\$30 \$25\$30  Outpatient Rehabilitation services \$25\$30 \$25\$30  Durable medical equipment 20% \$300 per day up to 5 days  Professional 20% No charge \$25\$30 \$25\$30  Outpatient Rehabilitation services \$25\$30 \$25\$30  Durable medical equipment 20% 20% 20% 10 5 days  Durable medical equipment 20% No charge No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charg		Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%			
health, or substance abuse needs  Substance Use disorder outpatient office visits  \$25\frac{30}{30}\$  Substance Use disorder other outpatient items and services  \$25\frac{30}{30}\$  \$25\frac{30}{30}\$  Substance Use inpatient facility fee (e.g. hospital room)  \$20\times	Mental health,	· ·					
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)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient services  Hospital  Professional  Professional  Outpatient Rehabilitation services  Skilled nursing care  Hospital  Substance Use disorder outpatient physician fee  20%  No charge  No charge  No charge  Progressional  Outpatient Rehabilitation services  Skilled nursing care  Hospice service  No charge  Oral Exam  Preventive - Cleaning Preventive - X-ray Sealants per Tooth  Not Covered	ociiaviorai	Mental/Behavioral health inpat	ent physician fee	20%		No charge	
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Delivery and all inpatient services  Hospital  Hospital  Professional  Professional  Professional  Outpatient Rehabilitation services  Skilled nursing care  Durable medical equipment  Hospital  20%  No charge  No charge  No charge  \$500 per day up to 5 days  No charge  Professional  Professional  20%  No charge  \$30  Outpatient Rehabilitation services  \$25\$30  Outpatient Habilitation services  \$25\$30  Skilled nursing care  Durable medical equipment  Hospice service  No charge  No charge  Preventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Not Covered	substance	Substance Use disorder outpa	tient office visits	<del>\$25</del> \$30		<del>\$25</del> <u>\$30</u>	
Substance Use inpatient facility lee (e.g. nospital room)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Prenatal care and preconception visits  No charge  Hospital 20% \$600 per day up to 5 days  Professional 20% No charge  Professional 20% No charge  Home health care (cost share per visit) 20% \$30  Outpatient Rehabilitation services \$25530 \$25530  Outpatient Habilitation services \$25530 \$25530  Skilled nursing care 20% \$300 per day up to 5 days  Durable medical equipment 20% \$300 per day up to 5 days  Durable medical equipment 20% 20%  Hospice service No charge  Preventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Not Covered  Not Covered		Substance Use disorder other	outpatient items and services	<del>\$25</del> <u>\$30</u>		<del>\$25</del> <u>\$30</u>	
Pregnancy  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient services  Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Skilled nursing care  Durable medical equipment  Hospital  20%  \$30  0utpatient Rehabilitation services  \$25530  \$22530  \$22530  \$22530  \$22530  \$22530  \$22530  \$22530  Durable medical equipment  Hospice service  No charge		Substance Use inpatient facilit	y fee (e.g. hospital room)	20%			
Pregnancy Delivery and all inpatient services Professional Professional Professional 20% No charge  Home health care (cost share per visit) 20% \$30 Outpatient Rehabilitation services \$25830 Outpatient Habilitation services \$25830 Skilled nursing care Outpatient Habilitation services 20% Skilled nursing care Professional 20% Skilled nursing care Outpatient Habilitation services 20% Skilled nursing care Professional 20% Skilled nursing care Outpatient Habilitation services 20% Skilled nursing care No charge Professional 20% Skilled nursing care No charge No charge No charge No charge Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Not Covered		Substance use disorder inpatie	ent physician fee	20%		No charge	
Delivery and all inpatient services   Flospital   20%   to 5 days		Prenatal care and preconcepti	on visits	No charge			
No charge			Hospital	20%			
Help recovering or other special health needs  Relation services  Outpatient Rehabilitation services  Outpatient Habilitation services  S25§30  Outpatient Habilitation services  S25§30  S25§						No charge	
Cutpatient Habilitation services \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$30 \$25\\$							
other special health needs     Skilled nursing care     20%     \$300 per day up to 5 days       Durable medical equipment     20%     20%       Hospice service     No charge     No charge       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 - Cleaning     Preventive - X-ray       Sealants per Tooth     Not Covered	неір					<del>\$25</del> <u>\$30</u>	
Durable medical equipment 20% 20% Hospice service No charge No charge Eye exam No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Child Dental Preventive - Cleaning Diagnostic Preventive - X-ray Sealants per Tooth  Not Covered Not Covered	other special	Skilled nursing care		20%			
Eye exam No charge No charge  1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Oral Exam Preventive - Cleaning Preventive - X-ray and Sealants per Tooth  Not Covered Not Covered						20%	
Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Oral Exam Preventive - Cleaning Diagnostic and Preventive - X-ray Sealants per Tooth  Not Covered							
Oral Exam Preventive - Cleaning Diagnostic and Preventive - X-ray Sealants per Tooth  Oral Exam Preventive - Cleaning Not Covered Not Covered	Child ave care	•	ontact lenses in lieu of glasses)				
Child Dental Diagnostic and     Preventive - Cleaning     Not Covered       Preventive - X-ray Sealants per Tooth     Not Covered		i pair of glasses per year (or contact lenses in fleu of glasses)				90	
and Sealants per Tooth Not Covered Not Covered							
	and Preventive	Sealants per Tooth Topical Fluoride Application	Not Covered		Not Covered		
Space Maintainers - Fixed  Child Dental  Dental  Child Dental	Child Dental						
Restorative Procedures Not Covered Not Covered	Basic		inas	Not Covered		Not Covered	
Crowns and Casts Not Covered		Crowns and Casts	UCS				
Child Dental Endodontics Not Covered	Child Dental						
Major Periodontics (other than maintenance) Not Covered Not Covered  Services Part August 1997	Sorvicos	,	enance)	Not Covered			
Prosthodontics Not Covered Oral Surgery Not Covered							
Child		<del>"</del>	ice	Not Course			
Orthodontics Medically necessary orthodontics Not Covered Not Covered							

#### 20182019 Patient-Centered Benefit Plan Designs 9.5 EHB Date: <del>June 15, 2017</del><u>January 18, 2018</u>

	Benefits and Coverage		Individual	
	ember Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan	
	- AV Calculator		<del>71.9%</del> <u>71.8%</u>	
	cludes a deductible? dividual deductible	Υe	es, Medical/Pharn N/A	nacy
Integrated Fa	mily deductible ductible, NOT integrated: Medical / Pharmacy / De	tol 64	N/A 2,500/ <del>\$130</del> \$200	/ ¢0
Family deduc	tible, NOT integrated: Medical / Pharmacy / Dental		5,000/ <del>\$260</del> \$400	
	of-pocket maximum		\$7,000\$7,550 \$14,000\$15,100	)
HSA plan: Self	only coverage deductible n: Individual deductible		N/A N/A	
noa ranny pia	n. muividual deductible		IN/A	
Common				Deductible
Medical Event	Service Type	Member	Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or conditio	n \$	<del>35<u>\$40</u></del>	
provider's office or clinic	Other practitioner office visit	\$	<del>35</del> \$40	
visit	Specialist visit	\$	<del>75</del> \$80	
	Preventive care/ screening/ immunization		charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$75	
	Imaging (CT/PET scans, MRIs)		\$300	
	Tier 1			Pharmac deductibl
Drugs to treat	Tier 2			Pharmac deductibl
condition	Tier 3		80\$90	Pharmac deductibl
	Tier 4	script aft	ductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)	:	\$350	
	Emergency room physician fee (waived if admitted)	No	charge	
Need immediate	Emergency mMedical transportation (including emergency and non- emergency)		\$250	Х
attention	Urgent care	\$	35 <u>\$40</u>	
	Facility fee (e.g. hospital room)		20%	Х
Hospital stay	Physician/surgeon fee		20%	
	Mental/Behavioral health outpatient office visits		35 <u>\$40</u>	
	Mental/Behavioral health other outpatient items and services		35 <u>\$40</u>	
	Mental/Behavioral health inpatient facility fee (e.g.hos	oital room)	20%	Х
Mental health,				
behavioral health, or	Mental/Behavioral health inpatient physician fee		20%	×
substance abuse needs	Substance Use disorder outpatient office visits		<del>35<u>\$</u>40</del>	
	Substance Use disorder other outpatient items and so	rvices \$	<del>35</del> \$40	
	Substance Use inpatient facility fee (e.g. hospital roor	1)	20%	Х
	Substance use disorder inpatient physician fee		20%	×
	Prenatal care and preconception visits		charge	^
Pregnancy	Delivery and all inpatient Hospital		20%	Х
, <b>,</b>	services Professional		20%	×
	Home health care (cost share per visit)		\$45	
Help recovering or	Outpatient Rehabilitation services Outpatient Habilitation services		35 <u>\$40</u> 35 <u>\$40</u>	
other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
Child eye care	Hospice service  Eye exam  1 pair of planses per year (or centert langue in lieu of ale	No	charge charge	
	pair of glasses per year (or contact lenses in lieu of gla  Oral Exam	sses) No	charge	
Child Dental	Preventive - Cleaning Preventive - X-ray			
Diagnosiii	Sealants per Tooth	Not	Covered	
and	Topical Fluoride Application Space Maintainers - Fixed			
and			Covered	
Diagnostic and Preventive  Child Dental Basic	Restorative Procedures	Not		
and Preventive Child Dental	Periodontal Maintenance Services	Not	Covered	
and Preventive Child Dental Basic Services		Not	Covered	
and Preventive Child Dental Basic Services Child Dental Major	Periodontal Maintenance Services Crowns and Casts		Covered	
and Preventive Child Dental Basic Services Child Dental	Periodontal Maintenance Services Crowns and Casts Endodontics			

Date: <del>June</del>	<del>3 15, 2017</del> January 18, 2018				
Summary of	Benefits and Coverage	CCSB		CCSB	
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance	Plan	Silver Copay Pla	n
Actuarial Value	e - AV Calculator	71.9%		71.4% <u>71.6</u>	
Plan design in	cludes a deductible?	Yes, Medical/Ph	armacy	Yes, Medical/Ph	armacy
	dividual deductible	N/A		N/A	
	amily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$2,000 / <del>\$125</del> <u>\$2</u>	<u>900</u> / \$0	N/A \$2,000 / <del>\$125</del> \$2	<u>00</u> / \$0
	ctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$4,000 / <del>\$250</del> <u>\$4</u> \$ <del>7,000</del> \$7,5		\$4,000 / \$ <del>250</del> <u>\$4</u> \$ <del>7,000</del> \$7,5	
	pocket maximum	\$14,000 <u>\$15,</u>		\$14,000 <u>\$15.</u>	
	f-only coverage deductible In: Individual deductible	N/A N/A		N/A N/A	
TIOA failing pia	III. IIIdividdal deddetible	IN/A		1977	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$45		\$45	
Health care provider's office or clinic	Other practitioner office visit	\$45		\$45	
visit	Specialist visit	<del>\$75</del> <u>\$80</u>		<del>\$75</del> <u>\$80</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 \$ <del>70</del> \$75		\$40 \$70 \$75	
1000	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	\$15	Pharmacy deductible	\$15	Pharmacy deductible
Drugs to treat	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible
illness or condition	Tier 3	\$85	Pharmacy deductible	\$85	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy	Pharmacy deductible	20% up to \$250 per script after pharmacy	Pharmacy deductible
Outro di ci	Surgery facility fee (e.g., ASC)	deductible 20%		deductible 20%	
Outpatient services	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Emergency mMedical transportation (including emergency and non-	\$250	Х	\$250	Х
attention	emergency) Urgent care	\$45		\$45	
	organi care	φ+3		φ+3	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	Х
	Physician/surgeon fee	20%	X	20%	×
	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,		200/	V	200/	V
behavioral health, or	Mental/Behavioral health inpatient physician fee	20%	Х	20%	×
substance abuse needs	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%	Х	20%	Х
	Substance use disorder inpatient physician fee	20%	Х	20%	×
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	20%	Х	20%	Х
	services Professional	20%	X	20%	×
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$45 \$45		\$45 \$45	
recovering or other special	Skilled nursing care	20%	Х	20%	Х
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in liquid glasses)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services			NIIO	
Child Doctal	Crowns and Casts Endodontics			Not Covered Not Covered	
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics			Not Covered	
	Oral Surgery			Not Covered	
Child	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Benefits and Coverage  Member Cost States a reductable?  Missessian Misses At Calculations  Party Repairs Assessing States a reductable?  Party Repairs Repairs Resident and a reductable and reductable	Date. June	<del>) 15, 2017</del> <u>January 18,</u>	2010		
Accounts Visite of includes a desidential of the Erichary and Capability (Company)  Plant design includes a desidential of the Erichary and Capability (Company)  Plant design includes a desidential of the Erichary (Company)  Including includes a desidential of the Erichary (Company)  Includes a	Summary of	Benefits and Coverage			
Parent expension includes a dedicatible   2,000, 100 migrated integrated and wide discounts   2,000, 100 migrated   1,000, 100 migra	Member Cost S	hare amounts describe the En	rollee's out of pocket costs.		
Integrated Reviolated Reductable  Remain productable  Remain produ	<b>Actuarial Value</b>	e - AV Calculator		<del>71.7%</del> 70.	<u>5%</u>
Dispet   Test   Control					
Machiditate double-close maintainum   Seption   Septio	Integrated Fa	mily deductible			
Individual obu-ed-pocker maximum  ### 1947   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945   1945					
Section   Section   Section   Section   Type   Membra Cost State   Defection   Section   Type   Membra Cost State   Defection   Section   Type   Membra Cost State   Defection   Applies   Section   Type   Membra Cost State   Defection   Applies   Section   Type   Membra Cost State   Defection   Applies   Section   Type   Membra Cost State   Type   Section   Type   Type   Section   Type   Ty	Individual Out-	-of-pocket maximum	arri namas yr Domar	<del>\$6,550</del> <u>\$6,</u>	
Monthair Cost Share   Primary care visit to breat an injury, libraes, or condition   20%   X	HSA plan: Self	only coverage deductible			
Primary care visit to breat an injury, illness, or condition   20%   X	HSA family pla	n: Individual deductible		\$2,700	
Primary care visit to breat an injury, illness, or condition   20%   X	Common				
Comparison   Com		Se	rvice Type	Member Cost Share	Deductible Applies
Comparison   Com		Primany care visit to treat an i	niuny illness or condition	20%	¥
provider or claims  Specialist visit  Specialist visit  Specialist visit  Specialist visit  Specialist visit  Specialist visit  Proventive care/ screening/ immunization  Not charge  Proventive care/ screening/ immunization  Not charge  System of the control of the charge of the cha		Timary care visit to treat air ii	ijury, iiiriess, or condition	2070	^
softice or clinic wist    Specialist visit   Preventive carel screening/ immunization   No charge		Other practitioner office visit		20%	· ·
Specialist visit	office or clinic			20%	^
Preventive cared screening immunication  Laboratory Teels  Laboratory Teels  Laboratory Teels  Laboratory Teels  Laboratory Teels  Laboratory Teels  Ter 1  Ter 2  Drugs to trust  Ter 2  Drugs to trust  Ter 3  Condition  Tier 3  Condition  Tier 3  Condition  Tier 4  Laboratory Teels  Suggery facility foe (e.g., ASC)  Loughtein visit  Emergency facility foe (e.g., ASC)  Loughtein visit  Emergency room physician fee (walved if admitted)  Emergency room facility fee (walved if admitted)  Emergency room facility fee (walved if admitted)  Emergency room physician fee (walved if admitted)  Emergency room physician fee (walved if admitted)  Lurgent care  Hospital stay  Physicianisuspon fee  Mental/Behavioral health outpatient office visits  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Substance Use disorder outpatient office visits  Workshall health, or substance Use disorder outpatient office visits  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Pregnancy  Substance Use disorder outpatient office visits  Dissistance Use disorder outpatient office visits  Child well-way and ill repetite physician fee  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Dispital results facility fee (e.g. hospital room)  All the results facility fee (e.g. hospital room)  Dispital results for the results of the result	visit	Specialist visit		20%	~
Laboratory Treats  Laboratory Tr		opecialist visit		2070	^
Tests   Management   Manageme			nmunization		Y
Tier 1 20% up to \$250 per	Tests	X-rays and Diagnostic Imagin		20%	Х
Drugs to treat Inter 2  20% up to \$250 per script  Tier 4  20% up to \$250 per script  Tier 4  20% up to \$250 per script  X  Surgery facility fee (e.g., ASC) Physician/surgeon fees  20% up to \$250 per script  X  X  20% up to \$250 per script  X  X  Emergency room facility fee (e.g., ASC) Physician/surgeon fees  20% up to \$250 per script  X  X  Emergency room facility fee (walved if admitted)  20% up to \$250 per script  X  X  Emergency room facility fee (walved if admitted)  20% up to \$250 per script  X  X  Mendal manufacture  4 consequency and decided transportation (including emergency and non-mergency)  4 consequency  4 conseque		Imaging (CT/PET scans, MRI	3)		X
Drugs to treat liver / Image of Condition Tear 3		Tier 1			Х
Drugs to treat liver / Image of Condition Tear 3				20% up to \$250 per	
Tear 3 20% up to \$250 per Script		Tier 2			Х
Tier 4  Tier 4  20% up to \$250 per script X  Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted)  Emergency room facility fee (waived if admitted)  Emergency room facility fee (waived if admitted)  Urgent care  Pregnancy  Absolute attention  Montal Facility fee (e.g., hospital room) Physician/surgeon fee  20%  X  Montal Behavioral health outpatient office visits  Absolute fee and the surgeon fee  20%  X  Montal Behavioral health other outpatient items and services  Amental Behavioral health other outpatient items and services  Amental Behavioral health inpatient facility fee (e.g. hospital room)  Substance abuse needs  Substance Use disorder outpatient office visits  20%  X  Substance Use disorder outpatient office visits  20%  X  Substance Use disorder outpatient office visits  20%  X  Substance Use disorder outpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Pregnancy  Preventive - Clearing  Preven		T. 0		20% up to \$250 per	v
Outpatient Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit  Emergency room facility fee (walved if admitted) Emergency room facility fee (walved if admitted)  Emergency room facility fee (walved if admitted)  Emergency room facility fee (walved if admitted)  Urgent care  Urgent care  Hospital stay  Facility fee (e.g. hospital room)  Physician/surgeon fee  Quy  Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient ferious visits  Mental/Behavioral health other outpatient ferious visits  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  Mental/Behavioral health inpatient physician fee  Substance Use disorder outpatient filters visits  Substance Use disorder outpatient liters and services  Substance Use disorder outpatient liters and services  Substance Use disorder outpatient fee usits  Substance Use disorder other outpatient liters and services  Substance Use disorder outpatient liters and services  Substance Use disorder outpatient facility fee (e.g. hospital room)  Substance Use disorder outpatient liters and services  Substance Use disorder outpatient liters and services  Substance Use disorder outpatient liters and services  Substance Use disorder outpatient physician fee  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Home health care (cost shee per visit)  Outpatient risabilitation services  Professional  Not Covered  Preventive - Cleaning  Preventive - Cleaning  Preventive - Cleaning  Preventive - Cleaning  Professional  Professional  Professional  Professional  Professional  Not Covered  Professional  Not Covered  Professional  Professional  Professional  Professional  Professional  Professional  Professional  Professional  Not Covered  Profe		ner 3			Х
Surgery facility fee (e.g., ASC)		Tier 4			×
Outpatient size assorices				<u> </u>	
Emergency room facility fee (walved if admitted)   20%   X					
Emergency room physician fee (walved if admitted)	services				
Emergency mMedical transportation (including emergency and non- emergency)		Emergency room facility fee (	vaived if admitted)	20%	Х
attention Urgent care Urgent care Urgent care Urgent care Urgent care  Amental/Behavioral health outpatient office visits  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 facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  20%  X  Mental/Behavioral health inpatient physician fee 20%  X  Substance Substance Use disorder outpatient diffice visits  Substance Use disorder outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Delivery and all inpatient Pregnancy  Pregnancy Delivery and all inpatient Holp recovering or recovering or recovering or Substance (cost share per visit)  Outpatient Rehabilitation services  Durabile medical equipment Hospice service  Preventive - Cleaning Preventive -		Emergency room physician fe	e (waived if admitted)	0%	X
Hospital stay Pacility fee (e.g. hospital room) Physician/surgeon fee  Mental/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  Dubles abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient office visits  Substance Use disorder other outpatient office visits  Dubles and preconception visits  Substance use disorder inpatient physician fee  Pregnancy  Pregn				20%	Х
Hospital stay Physician/surgeon fee 20% X Physician/surgeon fee 20% X  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 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 outpatient office visits 20% X  Substance Use disorder outpatient office visits 20% X  Substance Use disorder on outpatient items and services 20% X  Substance Use disorder on outpatient items and services 20% X  Prenatal care and preconception visits No charge  Pregnancy Delivery and all inpatient services 100% 100% 100% 100% 100% 100% 100% 100		emergency)			
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Physician/surgeon fee 20% X  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 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 outpatient items and services 20% X  Substance Use inpatient facility fee (e.g. hospital room) 20% X  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 20% X  Prenatal care and preconception visits No charge 20% X  Help Couly and all inpatient Physician fee 20% X  Home health care (cost share per visit) 20% X  Outpatient Rehabilitation services 20% X  Outpatient Rehabilitation services 20% X  Outpatient Habilitation services 20% X  Skilled nursing care 20% X  Child eye care 20% X  Child eye care 20% X  Child pental Diagnostic 30 Child pental Basic 30 Child pental 40 Child		3			
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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  Mental/Behavioral health inpatient physician fee 20% X  Substance Use disorder outpatient office visits 20% X  Substance Use disorder outpatient office visits 20% X  Substance Use disorder outpatient physician fee 20% X  Substance Use inpatient facility fee (e.g. hospital room) 20% X  Substance use disorder inpatient physician fee 20% X  Pregnancy Pregnancy Delivery and all inpatient Professional 20% X  Home health care (cost share per visit) 20% X  Outpatient Rehabilitation services 20% X  Outpatient Rehabilitation services 20% X  Coupatient Rehabilitation services 20% X  Coupatient Rehabilitation services 20% X  Child eye 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 frooth 1 pair of glasses per year frooth 1 pair of glasses Preventive - Cleaning Preventive -	Hospital stay		,		
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%  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)  Substance Use inpatient physician fee  20%  X  Prenatal care and preconception visits  No charge  Pregnancy  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Presented cost share per visit)  Outpatient Rehabilitation services  20%  X  Home health care (cost share per visit)  Outpatient Rehabilitation services  20%  X  United patient Habilitation services  20%  X  Silied nursing care  20%  X  Substance Use disorder outpatient physician fee  20%  X  V  A  Preventive A cost share per visit)  Outpatient Rehabilitation services  20%  X  Substance Use disorder inpatient physician fee  20%  X  X  V  A  Preventive A cost share per visit)  Outpatient Rehabilitation services  20%  X  Substance Use disorder outpatient fee (e.g. hospital room)  20%  X  V  A  Preventive A cost share per visit  Outpatient Rehabilitation services  20%  X  Substance Use disorder inpatient physician fee  20%  X  V  V  A  A  A  Outpatient Rehabilitation services  20%  X  V  Outpatient Rehabilitation services  20%  X  N  Outpatient Rehabilitation services  20%  X  X  Substance Use disorder outpatient fee (e.g. hospital room)  20%  X  V  Outpatient Rehabilitation services  20%  X  X  Substance Use disorder outpatient fee (e.g. hospital room)  20%  X  V  Outpatient Rehabilitation services  20%  X  X  Substance Use disorder outpatient fee (e.g. hospital room)  20%  X  V  Outpatient Rehabilitation services  20%  X  X  Substance Use disorder outpatient fee (e.g. hospital room)  20%  X  V  Outpatient Rehabilitation services  20%		, ,			
Mental/Behavioral health inpatient facility fee (e.g.hospital room)  Mental/Behavioral health inpatient physician fee  20%  X  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use disorder inpatient physician fee  20%  X  Substance Use disorder inpatient physician fee  20%  X  Substance Use disorder inpatient physician fee  Pregnancy  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient services  Professional  Professional  20%  X  Dupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Substance Use disorder outpatient physician fee  20%  X  X   V  Pregnancy  Delivery and all inpatient services  Dupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  V  V  V  V  V  V  V  V  V  V  V  V		Mental/Behavioral health outp	atient office visits	20%	Х
Mental/Behavioral health inpatient facility fee (e.g.hospital room)  Mental/Behavioral health inpatient physician fee  20%  X  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use disorder inpatient physician fee  20%  X  Substance Use disorder inpatient physician fee  20%  X  Substance Use disorder inpatient physician fee  Pregnancy  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient services  Professional  Professional  20%  X  Dupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Substance Use disorder outpatient physician fee  20%  X  X   V  Pregnancy  Delivery and all inpatient services  Dupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  Uupatient Rehabilitation services  20%  X  V  V  V  V  V  V  V  V  V  V  V  V					
Mental health, behavioral health behavioral health inpatient physician fee   20%   X		Mental/Behavioral health other outpatient items and services		20%	х
Mental health, behavioral health behavioral health inpatient physician fee   20%   X					
Dehavioral health, or substance abuse needs   Substance Use disorder outpatient office visits   20%   X	Montal boolth	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient Hospital 20% X  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Rehabilitation services  20% X  Coutpatient Rehabilitation services  20% X  Coutpatient Rehabilitation services  20% X  Coutpatient Rehabilitation services  Outpatient Rehabilitation services  Outpatient Rehabilitation services  Outpatient Rehabilitation services  20% X  Coutpatient Rehabilitation services  Outpatient Rehabilitation services  Over X  X  Coutpatient Rehabilitation services  Over X  X  Child Dental Preventive - Cleaning  Preventive - C	,	Mental/Behavioral health inpa	tient physician fee	20%	×
substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Delivery and all inpatient Hospital 20% X  Home health care (cost share per visit) 20% X  Home health care (cost share per visit) 20% X  Outpatient Rehabilitation services 20% X  Outpatient Rehabilitation services 20% X  Durable medical equipment 20% X  Child over care  Child Dental Preventive - Cleaning Preventive - Vary and Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontics (other than maintenance) Prost indontics Oral Surgery  Child Medically necessary orthodontics  Not Covered  Prosthodontics Oral Surgery  Child Medically necessary orthodontics					
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Prenatal care and preconception visits  Delivery and all inpatient services  Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  20%  X  Skilled nursing care  Durable medical equipment  Hospital 20%  X  Skilled nursing care  Durable medical equipment  Hospice service  1 pair of glasses per year (or contact lenses in lieu of glasses)  Child Dental  Diagnostic and Preventive - Cleaning  Preventive - Cleaning  Preventive - Topical Fluoride Application  Space Maintainers - Fixed  Child Dental  Endodontics  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Prosthodontics  Oral Surgery  Child Medically necessary orthodontics  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered		Substance Use disorder outpo	atient office visits	20%	Х
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Prenatal care and preconception visits  Delivery and all inpatient services  Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  20%  X  Skilled nursing care  Durable medical equipment  Hospital 20%  X  Skilled nursing care  Durable medical equipment  Hospice service  1 pair of glasses per year (or contact lenses in lieu of glasses)  Child Dental  Diagnostic and Preventive - Cleaning  Preventive - Cleaning  Preventive - Topical Fluoride Application  Space Maintainers - Fixed  Child Dental  Endodontics  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Prosthodontics  Oral Surgery  Child Medically necessary orthodontics  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered					
Substance use disorder inpatient physician fee 20% X  Prenatal care and preconception visits No charge  Delivery and all inpatient services Hospital 20% X  Delivery and all inpatient services Hospital 20% X  Home health care (cost share per visit) 20% X  Outpatient Rehabilitation services 20% X  Outpatient Habilitation services 20% X  Skilled nursing care 20% X  Skilled nursing care 20% X  Child excare 1 pair of glasses per year (or contact lenses in lieu of glasses)  Child Dental Diagnostic Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Periodontal Maintenance Services  Crowns and Casts Endodontics Oral Surgery  Child Dental Privation Restorative Precedures Prodontics (other than maintenance)  Provided Medically necessary orthodontics Not Covered  Child Medically necessary orthodontics  Oral Surgery  Not Covered  Not Covered		Substance Use disorder other	outpatient items and services	20%	x
Substance use disorder inpatient physician fee 20% X  Prenatal care and preconception visits No charge  Delivery and all inpatient services Hospital 20% X  Delivery and all inpatient services Hospital 20% X  Home health care (cost share per visit) 20% X  Outpatient Rehabilitation services 20% X  Outpatient Habilitation services 20% X  Skilled nursing care 20% X  Skilled nursing care 20% X  Child excare 1 pair of glasses per year (or contact lenses in lieu of glasses)  Child Dental Diagnostic Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Periodontal Maintenance Services  Crowns and Casts Endodontics Oral Surgery  Child Dental Privation Restorative Precedures Prodontics (other than maintenance)  Provided Medically necessary orthodontics Not Covered  Child Medically necessary orthodontics  Oral Surgery  Not Covered  Not Covered					
Pregnancy  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient services  Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  20%  X  Outpatient Habilitation services  20%  X  Skilled nursing care  Durable medical equipment  Hospital  Survices  20%  X  A  A  A  A  Child Dental  Diagnostic and  Child Dental  Basic  Child Dental  Basic  Child Dental  Basic  Child Dental  Basic  Child Dental  Major  Pervices  Prosthodontics  Oral Surgery  Child  Child Dental  Prosessional  A  Hospital  20%  X  A  A  A  A  A  A  A  A  A  A  A  A		Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
Pregnancy Delivery and all inpatient services Professional Professional Dupatient Rehabilitation services Dutpatient Habilitation services Outpatient Habilitation services Dutpatient Habilitation services Skilled nursing care Skilled nursing care Durable medical equipment Hospital Durable medical equipment Hospital Durable medical equipment Hospital Durable medical equipment Durable medical equ		Substance use disorder inpati	ent physician fee	20%	Х
services  Professional  20%  X  Uutpatient Rehabilitation services 20% X  Outpatient Rehabilitation services 20% X  Outpatient Habilitation services 20% X  Skilled nursing care 3killed nursing care 4killed nursing care		Prenatal care and preconcept	ion visits	No charge	
Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Outpatient Habilitation services  20%  X  Outpatient Habilitation services  20%  X  Skilled nursing care  Ourable medical equipment  Hospice service  Eye exam  Child eye care  Oral Exam  Preventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Space Maintainers - Fixed  Child Dental  Basic  Services  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Prosthodontics  Oral Surgery  Child  Medically pecessary orthodontics  Not Covered  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Oral Surgery  Child  Medically pecessary orthodontics	Pregnancy		Hospital	20%	Х
Help recovering or other special health needs  Durable medical equipment Hospice service  Child eye care  Child Dental Diagnostic and Preventive - X-ray Sacial Restorative Procedures Services  Periodontics  Child Dental Basic Services  Prosthodontics Child Dental Basic Services  Prosthodontics Oral Surgery  Child Dental Child De					
Outpatient Habilitation services 20% X  Skilled nursing care 20% X  Skilled nursing care 20% X  Durable medical equipment 20% X  Hospice service 0% X  Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Oral Exam Not Covered  Diagnostic Preventive - Cleaning Preventive - X-ray Sealants per Tooth Space Maintainers - Fixed Preventive Preventive Preventive Preventive Preventive Space Maintainers - Fixed Periodontal Maintenance Services Periodontal Maintenance Services Prosthodontics Oral Surgery  Child Dental Medically necessary orthodontics Not Covered Prosthodontics Oral Surgery  Child Medically necessary orthodontics Not Covered Prostrodontics Not Covered Prostrodontics Not Covered Prostrodontics Not Covered Prosthodontics Not Covered Prosthodontics Oral Surgery	Hole				
health needs  Durable medical equipment 20% X Hospice service 0% No charge  Eye exam No charge  1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Oral Exam Preventive - Cleaning Preventive - Varay Sealants per Tooth Preventive - Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Restorative Procedures Services Periodontal Maintenance Services  Child Dental Major Preventive (Child Dental Maintenance) Preventive Prosthodontics Oral Surgery  Child Medically necessary orthodontics Oral Surgery  Not Covered		Outpatient Habilitation service	S	20%	Х
Durable medical equipment Hospice service  O% X  Hospice service  O% X  Eye exam No charge  1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Major Services Prosthodontics Oral Surgery  Child Medically necessary orthodontics Oral Surgery  Not Covered  Not Covered  Not Covered  Not Covered		Skilled nursing care		20%	Х
Eye exam No charge  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 Preventive Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Oral Surgery  Child Medically pecessary orthodontics Oral Surgery  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered					
Oral Exam  Child Dental Diagnostic and Sealants per Tooth Preventive - Cleaning Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Periodontics (other than maintenance) Prosthodontics Oral Surgery  Child Medically pecessary orthodontics Not Covered	Child ove com	Eye exam			
Child Dental Diagnostic Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Procedures Restorative Procedures Periodontal Maintenance Services Periodontal Maintenance Services Prosthodontics Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery  Child Medically necessary orthodontics Not Covered Prosthodontics Not Covered Not	Office eye care	i pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Diagnostic and Sealants per Tooth Space Maintainers - Fixed Sealants Per Tooth Space Maintainers - Fixed Services Periodontal Maintenance Services Endodontics Oral Surgery  Child Dental Major Periodontics (other than maintenance) Not Covered Services Prosthodontics Oral Surgery  Child Medically necessary orthodontics Not Covered Not Cove	Child Dental				
Preventive Topical Fluoride Application Space Maintainers - Fixed Sance Maintainers - Fixed Sance Maintainers - Fixed Sance Maintainers - Fixed Sance Periodontal Restorative Procedures Not Covered Periodontal Maintenance Services Crowns and Casts Endodontics Sance Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered Sance Periodontics Not Covered Sance Per		Preventive - X-ray		Not Covered	
Child Dental Basic Restorative Procedures Restorative Procedures Restorative Procedures Restorative Procedures Restorative Procedures Restorative Procedures Restoration Resto		Topical Fluoride Application			
Basic Restorative Procedures Not Covered  Services Periodontal Maintenance Services Crowns and Casts Endodontics Major Periodontics (other than maintenance) Services Prosthodontics Oral Surgery  Child Medically necessary orthodontics Medically necessary orthodontics Not Covered	Child Dental	Space Maintainers - Fixed			
Child Dental Major Periodontics (other than maintenance) Periodontics (other than maintenance) Prosthodontics Oral Surgery  Child Medically necessary orthodontics Not Covered  Not Covered	Basic	Restorative Procedures		Not Covered	
Child Dental Major Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery  Child Medically necessary orthodontics Not Covered	Services		rices		
Services Prosthodontics Oral Surgery  Child Medically necessary orthodontics Not Covered	Child Dental				
Child Medically necessary orthodontics Not Covered			tenance)	Not Covered	
Child Medically necessary orthodontics Not Covered	30.71083				
Orthodontics Not Covered	Child		tion	Not Carrain	
		iviedically necessary orthodor	ucs	Not Covered	

### 20182019 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: June 15, 2017 January 18, 2018

Member Cost Sh	hare amounts describe the En	rollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% F	
Actuarial Value	- AV Calculator		93.9%94		<del>88.0%</del> <u>87.9%</u>	
	cludes a deductible?		Yes, Medical/F	Pharmacy	Yes, Medical/Pha	rmacy
	dividual deductible mily deductible		N/A N/A		N/A N/A	
	ductible, NOT integrated: M tible, NOT integrated: Medi		\$75 / \$0 \$150 / \$0		\$650 / \$50 / \$0 \$1,300 / \$100 / \$0	
Individual Out-	-of-pocket maximum	car / marmacy / Demai	\$1,00	0	<del>\$2,450</del> <u>\$2,60</u>	<u>)</u>
	oocket maximum only coverage deductible		\$2,00 N/A	0	<del>\$4,900</del> <u>\$5,20</u> N/A	<u>)</u>
HSA family plai	n: Individual deductible		N/A		N/A	
Common			Member Cost	Deductible		Deductible
Medical Event	Se	ervice Type	Share	Applies	Member Cost Share	Applies
	Primary care visit to treat an i	njury, illness, or condition	\$5		<del>\$10</del> \$15	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		<del>\$10</del> \$15	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in	mmunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imagin	g	\$8 \$8		\$15 <u>\$25\$30</u>	
	Imaging (CT/PET scans, MRI	s)	\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat	Tier 2		\$10		\$20	Pharmacy deductible
condition	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
	Surgery facility fee (e.g., ASC	;)	10%		15%	
services	Physician/surgeon fees Outpatient visit		10% 10%		15% 15%	
	Emergency room facility fee (	waived if admitted)	\$50		\$100	
	Emergency room physician fe	ee (waived if admitted)	No charge		No charge	
immediate	Emergency mMedical transpo emergency)	ortation (including emergency and non-	\$30	Х	\$75	Х
attention	Urgent care		\$5		<del>\$10</del> \$15	
	Facility fee (e.g. hospital roon	1)	10%	Х	15%	Х
Hospitai stay	Physician/surgeon fee	''	10%	X	15%	×
	Mental/Behavioral health outpatient office visits		\$5		\$10 <u>\$</u> 15	
	Mental/Behavioral health othe	\$5		\$10 <u>\$15</u>		
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health,	Mental/Behavioral health inpa		10%	Х	15%	×
health, or substance	Substance Use disorder outp		\$5	^	\$10 <u>\$15</u>	X
	Substance Use disorder othe	r outpatient items and services	\$5		<del>\$10</del> <u>\$15</u>	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%	Х	15%	Х
	Substance use disorder inpat	ient physician fee	10%	Х	15%	×
	Prenatal care and preconcep	tion visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	Х	15%	Х
	Home health care (cost share	Professional per visit)	10% \$3	X	15% \$15	×
Heln	Outpatient Rehabilitation serv	rices	\$5		<del>\$10</del> \$15	
recovering or	Outpatient Habilitation service	es	\$5	V/	\$10 <u>\$15</u>	
health needs	Skilled nursing care		10%	Х	15%	Х
	Durable medical equipment Hospice service		10% No charge		15% No charge	
Child ave 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	Oral Exam Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application		22.5.00			
Child Dental	Space Maintainers - Fixed  Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Ser Crowns and Casts	vices	140t Covered		MOT COAGLED	
Child Dental	Endodontics					
Sarvicas	Periodontics (other than mair Prosthodontics	tenance)	Not Covered		Not Covered	
	Oral Surgery					

Date: June	15, 2017 January 18,	<u>2018</u>		
Summary of	Benefits and Coverage			
Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan 200%-250% FP	L
Actuarial Value	e - AV Calculator		73.9%	
	cludes a deductible?		Yes, Medical/Pharr	macy
	dividual deductible		N/A N/A	
Individual de	ductible, NOT integrated: Me		\$2,200 / <del>\$130</del> <u>\$175</u>	
	ctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$4,400 / \$260 <u>\$350</u> \$5,850 <u>\$6,300</u>	
	pocket maximum -only coverage deductible		<del>\$11,700</del> <u>\$12,60</u> N/A	
	n: Individual deductible		N/A	
Common Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir		<del>\$30</del> <u>\$35</u>	
Health care provider's office or clinic	Other practitioner office visit		\$ <del>30</del> <u>\$35</u>	
visit	Specialist visit		\$75	
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$75	
. 0010	Imaging (CT/PET scans, MRIs		\$300	
	Tier 1		\$15	Pharmac deductible
Drugs to treat	Tier 2		\$50	Pharmac
condition	Tier 3		\$75	Pharmac deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac
Outpatient	Surgery facility fee (e.g., ASC)		20%	
services	Physician/surgeon fees Outpatient visit		20%	
	Emergency room facility fee (v	vaived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)		No charge	
Need immediate attention	Emergency mMedical transportation (including emergency and non- emergency)		\$250	Х
	Urgent care		<del>\$30</del> <u>\$35</u>	
Hospital stay	Facility fee (e.g. hospital room	)	20%	Х
	Physician/surgeon fee		20%	-X-
	Mental/Behavioral health outp	atient office visits	<del>\$30</del> <u>\$35</u>	
	Mental/Behavioral health othe	r outpatient items and services	\$ <del>30</del> \$35	
	Mental/Behavioral health inpa	ient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	ient physician fee	20%	×
health, or substance abuse needs	Substance Use disorder outpa	tient office visits	\$ <del>30</del> \$35	
	Substance Use disorder other outpatient items and services		\$ <del>30</del> \$35	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х
	Substance use disorder inpati	ent physician fee	20%	×
	Prenatal care and preconcepti	on visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	X
	Home health care (cost share	per visit)	\$40	-
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$30\$35 \$30\$35	
recovering or other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service		No charge	

	Timaly sale visit to treat air ii	ijury, infecco, or containon	φοο <u>φοο</u>	
Health care provider's office or clinic	Other practitioner office visit		\$ <del>30</del> \$35	
visit	Specialist visit		\$75	
	Preventive care/ screening/ im	nmunization	No charge	
	Laboratory Tests	THAT I LOCATION	\$35	
Tests	X-rays and Diagnostic Imaging		\$75	
	Imaging (CT/PET scans, MRIs	:)	\$300	
	Tier 1		\$15	Pharmacy deductible
Drugs to treat illness or	Tier 2		\$50	Pharmacy deductible
condition	Tier 3		\$75	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC)		20%	
services	Physician/surgeon fees Outpatient visit		20% 20%	
	Emergency room facility fee (v	valved if admitted)	\$350	
	Emergency room physician fee	e (waived if admitted)	No charge	
Need immediate attention	Emergency mMedical transportemergency)	rtation_(including emergency and non-	\$250	Х
attention	Urgent care		\$ <del>30</del> \$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	Х
,,	Physician/surgeon fee		20%	- <del>X-</del>
	Mental/Behavioral health outpo	atient office visits	\$ <del>30</del> \$35	
	Mental/Behavioral health other	r outpatient items and services	\$ <del>30</del> \$35	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee		20%	×
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$ <del>30</del> \$35	
	Substance Use disorder other outpatient items and services		\$ <del>30</del> \$35	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х
	Substance use disorder inpation	ent physician fee	20%	×
	Prenatal care and preconcepti	· · ·	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	×
	Home health care (cost share		\$40	^
Help	Outpatient Rehabilitation servi	ces	\$30 <u>\$35</u>	
recovering or	Outpatient Habilitation service	S	\$30 <u>\$35</u>	
	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
Child eye care		ontact lenses in lieu of glasses)	No charge	
	Oral Exam		. to onarge	
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		Not Covered	
Services	Periodontal Maintenance Serv	ices		
	Crowns and Casts			
Child Dental	Endodontics	,		
Major Services	Periodontics (other than maint	enance)	Not Covered	
Jei vices	Prosthodontics Oral Surgery			
Child Orthodontics	Medically necessary orthodon	tics	Not Covered	

	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	Bronz HDHP P	
ctuarial Value - AV Calculator		<del>60.8%</del> <u>60.9%</u>		<del>61.4%</del> <u>61.6%</u>	
	cludes a deductible?	Yes, Medical/Pha	ırmacy	Yes, integ	
Integrated Fa	dividual deductible mily deductible	N/A N/A		\$4,800 <u>\$6,000</u> i \$9,600 <u>\$12,000</u>	
	ductible, NOT integrated: Medical / Pharmacy / Dental ctible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$12,600 / \$1,000		N/A N/A	
ndividual Out-	-of-pocket maximum	<del>\$7,000</del> <u>\$7,55</u>	<u>i0</u>	<del>\$6,550</del> <u>\$6</u>	
HSA plan: Self	pocket maximum -only coverage deductible	<del>\$14,000</del> \$ <u>15,1</u> N/A	<u>00</u>	<del>\$13,100</del> <u>\$1</u> \$4,800	0
HSA family pla	n: Individual deductible	N/A		\$4,800	)
Common			Deductible	Member Cost	Deductibl
Medical Event	Service Type	Member Cost Share	Applies After 1st three	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$75	non-preventive visits	40%	Х
Health care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	Х
visit	Specialist visit	\$105	After 1st three non-preventive visits	40%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 100%	X	40% 40%	X
	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%	X	40%	X
services	Physician/surgeon fees Outpatient visit	100% 100%	X	40% 40%	X
	Emergency room facility fee (waived if admitted)	100%	X	40%	X
	Emergency room physician fee (waived if admitted)	No charge	^	0%	X
Need	Emergency mMedical transportation (including emergency and non-	-		-	
mmediate	emergency)	100%	Х	40%	Х
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х
	Facility fee (e.g. hospital room)	100%	Х	40%	Х
Hospital stay	Physician/surgeon fee	100%	X	40%	Х
	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health other outpatient items and services	\$75	х	40%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	Х
Mental health,	Mental/Behavioral health inpatient physician fee	100%	X	40%	X
behavioral health, or	Working Borian Guill Inpution physician Too	10070	^	4070	^
substance					
abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	Х
abuse needs	Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services	\$75 \$75	non-preventive	40%	x
abuse needs			non-preventive visits		
abuse needs	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)	\$75 100%	non-preventive visits  X	40%	х
abuse needs	Substance Use disorder other outpatient items and services	\$75	non-preventive visits	40%	x
abuse needs	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee	\$75 100% 100%	non-preventive visits  X	40% 40% 40%	x
	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital Professional	\$75 100% 100% No charge	non-preventive visits  X  X  X	40% 40% 40% No charge	X X X
	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital Professional  Home health care (cost share per visit)	\$75  100%  100%  No charge  100%  100%  100%	non-preventive visits  X  X  X	40% 40% 40% No charge 40% 40% 40%	X X X X X X
Pregnancy	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital professional  Home health care (cost share per visit)  Outpatient Rehabilitation services	\$75  100%  100%  No charge  100%  100%	non-preventive visits  X  X  X  X  X	40% 40% 40% No charge 40%	X X X
Pregnancy Help recovering or other special	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital Professional  Home health care (cost share per visit)	\$75 100% 100% No charge 100% 100% \$75	non-preventive visits  X  X  X  X  X	40% 40% 40% No charge 40% 40% 40%	X X X X X X X X X X
Pregnancy Help recovering or other special	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital services  Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$100%  100%	non-preventive visits  X  X  X  X  X  X  X	40% 40% 40% No charge 40% 40% 40% 40%	x
Pregnancy Help recovering or other special	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$75  \$100%  100%  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40% 40% No charge 40% 40% 40% 40% 40% 40% 40% 60%	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	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital Professional  Home health care (cost share per visit)  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$75  100%  100%  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40% 40% No charge 40% 40% 40% 40% 40% 40% 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	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$75  \$100%  100%  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40% 40% No charge 40% 40% 40% 40% 40% 40% 40% 60%	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 eye care	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$75  100%  100%  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40% 40% No charge 40% 40% 40% 40% 40% 40% 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 eye care  Child Dental Diagnostic	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient Hospital Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$75  100%  100%  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40% 40% No charge 40% 40% 40% 40% 40% 40% 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 eye care  Child Dental Diagnostic and	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Professional  Hospital professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application	\$75  100%  100%  No charge  100%  100%  \$75  \$75  100%  No charge  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40%  40%  40%  No charge  40%  40%  40%  40%  40%  40%  No charge  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 eye care  Child Dental Diagnostic and Preventive	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - Cleaning  Preventive - Tooth  Topical Fluoride Application  Space Maintainers - Fixed	\$75  100%  100%  No charge  100%  100%  \$75  \$75  100%  No charge  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40%  40%  40%  No charge  40%  40%  40%  40%  40%  40%  No charge  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 eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Delivery and all inpatient Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures	\$75  100%  100%  No charge  100%  100%  \$75  \$75  100%  No charge  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40%  40%  40%  No charge  40%  40%  40%  40%  40%  40%  No charge  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 eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - Cleaning  Preventive - Tooth  Topical Fluoride Application  Space Maintainers - Fixed	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$100%  100%  No charge  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40% 40% No charge 40% 40% 40% 40% 40% 50% No charge 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 bental Diagnostic and Preventive  Child Dental Basic Services  Child Dental	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts  Endodontics	\$75  100%  100%  No charge  100%  100%  \$75  \$75  100%  No charge  No charge  No charge  No charge  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40%  40%  No charge  40%  40%  40%  40%  40%  40%  No charge  No charge  No charge  Not Covered	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	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Delivery and all inpatient Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)	\$75  100%  100%  No charge  100%  100%  \$75  \$75  \$100%  100%  No charge  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40% 40% No charge 40% 40% 40% 40% 40% 50% No charge 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 bental Diagnostic and Preventive  Child Dental Basic Services  Child Dental	Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Hospital Professional  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts  Endodontics	\$75  100%  100%  No charge  100%  100%  \$75  \$75  100%  No charge  No charge  No charge  No charge  No charge  No charge	non-preventive visits  X  X  X  X  X  X  X  X  X  X  X	40%  40%  No charge  40%  40%  40%  40%  40%  40%  No charge  No charge  No charge  Not Covered	x x x x x x x x x x x x x x x x x x x

	hare amounts describe the En	rollee's out of pocket costs.	Catastro	ohic Plan
	- AV Calculator		Yes, int	egrated
Integrated Inc	dividual deductible		\$ <del>7,350</del> \$7,90	0 integrated
	mily deductible ductible, NOT integrated: Me	odical / Pharmacy / Dental	\$14,700 <u>\$15,8</u> N	
	tible, NOT integrated: Medic		N/	
	of-pocket maximum		\$7,350 \$14,700	
HSA plan: Self	only coverage deductible		N/	'A
HSA family pla	n: Individual deductible		N/	Ά
Common			Member Cost	
Common Medical Event	Se	rvice Type	Share	Deductible Applies
	Primary care visit to treat an in	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%	X
	Preventive care/ screening/ in	nmunization	No charge	
	Laboratory Tests		0%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRI:		0%	X
		5)		
	Tier 1		0%	Х
Drugs to treat illness or	Tier 2		0%	Х
condition	Tier 3		0%	Х
	Tier 4		0%	X
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	)	0% 0%	X
services	Outpatient visit		0%	X
	Emergency room facility fee (v	waived if admitted)	0%	Х
	Emergency room physician fe	e (waived if admitted)	No charge	
Need immediate	Emergency mMedical transportation (including emergency and non- emergency)		0%	Х
attention	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room	n)	0%	Х
,	Physician/surgeon fee		0%	Х
	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	Х
Mental health.	Mental/Behavioral health inpatient 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 outpatient office visits		0%	After 1st three non-preventiv 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 inpati	ient physician fee	0%	Х
	Prenatal care and preconcept		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 service Outpatient Habilitation service		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	and the second of the second o	No charge	.,
	1 pair of glasses per year (or of Oral Exam	Johnact renses in lieu of glasses)	0%	Х
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
Obild Day 1	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		Not Covered	
Services	Periodontal Maintenance Serv Crowns and Casts	rices		
Child Dental	Endodontics			
Major Services	Periodontics (other than main	tenance)	Not Covered	
20111005	Prosthodontics Oral Surgery			
Child	Medically necessary orthodon		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 \$2,700 for Plan Year 2018 XXXX. 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	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.
	Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based
3	on drug safety, efficacy and cost or;
	Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	Drugs that are biologics and drugs that the Food and
	Drug Administration (FDA) or drug manufacturer requires to
	be distributed through specialty pharmacies;
4	2) Drugs that require the enrollee to have special training or
-	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.