Covered California 2018 2019 Patient-Centered Benefit Plan Designs¹

Final Proposed Board-approved June 15, 2017^{2_3}March 15, 2018

¹ These are the Standard Benefit Plan Designs pursuant to Government Code Section 100504(c). ² Clerical adjustment made to the AV for Silver 87 on March 21, 2017 to reflect final AV certification; adjustment made on April 18, 2017 to correctly reference the 2018 Dental Copay Schedule rather than the 2017 Schedule

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

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Member Cost Share amounts de	scribe the Enrollee's out of pocket costs.	
Actuarial Value - AV Calculato	or	

		Coinsurance	Fian	Copay Pla	
Actuarial Value - A	V Calculator	91.2% 91.7	%	88.1%<u>88.9</u>	%
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	D	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$	
	Individual Out–of–pocket maximum	\$3,350	-	\$3,350	-
		\$6,700		\$6,700	
	Family Out-of-pocket maximum				
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
	· Preventive care/ screening/ immunization				
	-	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
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	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Emergency mMedical transportation (including emergency and non- emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) <u>for inpatient stay (including labor and</u> delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs	Skilled nursing care			5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		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	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See <u>20182019</u> Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 20102010	
Major	Periodontics (other than maintenance)	50%		See <u>20182019</u> Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child					

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-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Gold		Gold	
		Coinsurance	Plan	Copay Pla	
ctuarial Value - A		81.8%		78.4%<u>78.1</u>	<u>%</u>
	Plan design includes a deductible?	NO		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0	2	\$0 \$0 / \$0 / \$	0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$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			\$6,000<u>\$7,2</u> \$12,000<u>\$14</u>,	
	HSA plan: Self-only coverage deductible		+00	<u>۳۲2,000 په ۲4,</u> N/A	400
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$25\$30	Applies	\$25 <u>\$30</u>	Аррие
Health care provider's	Other practitioner office visit	<u>\$25\$30</u>		<u>\$25\$30</u>	
office or clinic	Specialist visit	\$55		\$55	
VISIL					
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35		\$35	
Fests	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
llness or condition	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per		20% up to \$250 per	
		script		script	
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$300	
services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Emergency mMedical transportation (including emergency and non-	\$250		\$250	
	emergency) Urgent care	<u>\$25\$30</u>		\$25 \$30	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$600 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%		5 days No charge	
	Mental/behavioral health and substance use disorder outpatient office	2070		No charge	
Mental health, behavioral health, or	visits	<u>\$25\$30</u>		<u>\$25\$30</u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<u>\$25\$30</u>		<u>\$25\$30</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$ <u>25\$30</u>		<u>\$25\$30</u>	
recovering or		20%		\$300 per day up to	
other special health needs	Skilled nursing care			5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
. Lye ouro	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2018 2019	
Basic		20%		Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2018 2019	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				

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Summary of Benefits and Coverage

Child Orthodontics

Medically necessary orthodontics

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan	
Actuarial Value - A	·	71.9% 71.8%	
	Plan design includes a deductible?		201/
	Integrated Individual deductible	Yes, Medical/Pharm N/A	асу
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500/ \$130<u></u>\$200 /	\$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ <u>\$260</u> \$400 /	\$0
	Individual Out-of-pocket maximum	\$7,000<u>\$</u>7,550	
	Family Out-of-pocket maximum	<u>\$14,000\$15,100</u>	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35<u>\$40</u>	
Health care provider's office or clinic	Other practitioner office visit	\$35<u>\$40</u>	
visit	Specialist visit	\$75<u>\$80</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Tests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
			Pharmacy
	Tier 1	\$15	deductible
Drugs to treat illness or	Tier 2	\$55	Pharmacy deductible
condition	Tier 3	\$80	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy
		after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Emergency mMedical transportation (including emergency and non- emergency)	\$250	х
	Urgent care	<u>\$35\$40</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	×
		2070	*
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35<u></u>\$40	
health, or substance	Mantal/babaviaral backh and substance use disorder other substant		
abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<u>\$35\$40</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	<u>\$35\$40</u>	
recovering or other special	Skilled nursing care	20%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	² 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	-	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed Restorative Procedures		
Basic		20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental			
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		

50%

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•	enefits and Coverage e amounts describe the Enrollee's out of pocket costs.	CCSB Silver Coinsurance Plar	1	CCSB Silver Copay Plan	
ctuarial Value - A	AV Calculator	71.9%	•	71.4% 71.6%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$125<u></u>\$200 /		\$2,000 / \$125<u>\$200</u> /	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / <u>\$250<u></u>\$400</u> / \$7,000 \$7,550	\$0	\$4,000 / <u>\$250\$400</u> /	\$0
	Individual Out–of–pocket maximum Family Out-of-pocket maximum	\$14,000 <u>\$15,100</u>		\$7,000<u>\$</u>7,550 \$14,000<u>\$15,100</u>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl 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	\$75<u>\$80</u>		\$75<u></u>\$80	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$70<u></u>\$75		\$70<u></u>\$75	
	Imaging (CT/PET scans, MRIs)	20%	D'	\$300	5
	Tier 1	\$15	Pharmacy deductible	\$15	Pharma deductib
Drugs to treat illness or condition	Tier 2	\$55	Pharmacy	\$55	Pharma
			deductible Pharmacy		deductib Pharma
	Tier 3	\$85	deductible	\$85	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20%		20%	
Outpatient	Physician/surgeon fees	20%		20%	
services	Outpatient visit	20%		20%	
_	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Emergency mMedical transportation (including emergency and non-	\$250	х	\$250	х
attention	<u>emergency)</u> Urgent care	\$45		\$45	
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	x x	20%	X X
		20%	^	20%	A
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$45		\$45	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$45		\$45	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$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	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 20182019 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		See 20182019 Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 20182019 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				

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Child

Orthodontics

Medically necessary orthodontics

CCSB Summary of Benefits and Coverage Silver HDHP Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator 71.7%70.5% Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2,000<u>\$2,500</u> integrated Integrated Family deductible \$4,000<u>\$5,000</u> integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum \$6,550<u>\$6,650</u> Family Out-of-pocket maximum \$13,100<u></u>\$13,300 HSA plan: Self-only coverage deductible \$2.000\$2.500 HSA family plan: Individual deductible \$2,700See endnote Common Deductible Service Type Member Cost Share Medical Event Applies Primary care visit to treat an injury, illness, or condition 20% Х Health care Other practitioner office visit 20% Х provider's office or clinic Specialist visit 20% visit Х Preventive care/ screening/ immunization No charge Laboratory Tests 20% Х Tests X-rays and Diagnostic Imaging 20% Х Imaging (CT/PET scans, MRIs) 20% Х 20% up to \$250 per Tier 1 Х script 20% up to \$250 per Tier 2 Х Drugs to treat script illness or condition 20% up to \$250 per Tier 3 Х cript 20% up to \$250 per Tier 4 Х script 20% Surgery facility fee (e.g., ASC) Х Outpatient services Physician/surgeon fees 20% Х Outpatient visit 20% Х Emergency room facility fee (waived if admitted) 20% Х Need immediate Emergency room physician fee (waived if admitted) 0% х Emergency mMedical transportation (including emergency and non-20% Х attention emergency) 20% х Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 20% х Hospital stay Physician/surgeon fee 20% х Mental health, behavioral Mental/behavioral health and substance use disorder outpatient office 20% Х visits health. or substance Mental/behavioral health and substance use disorder other outpatient 20% х abuse needs items and services Pregnancy Prenatal care and preconception visits No charge 20% Home health care (cost share per visit) Х Outpatient Rehabilitation and Habilitation services 20% х Help . recovering or Skilled nursing care 20% Х other special health needs Durable medical equipment 20% Х Hospice service 0% Х Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures 20% Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Major Services 50% Periodontics (other than maintenance) Prosthodontics Oral Surgery

50%

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	nefits and Coverage	Silver P	lan	Silver Plan	
	amounts describe the Enrollee's out of pocket costs.	100%-150%	% FPL	150%-200% FPL	-
Actuarial Value - A		93.9%<u>94</u>		88.0% <u>87.9%</u>	
	Plan design includes a deductible?	Yes, Medical/F N/A	Pharmacy	Yes, Medical/Pharm N/A	iacy
	Integrated Individual deductible Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$1,300 / \$100 / \$	0
	Individual Out–of–pocket maximum	\$1,000		\$2,450 <u>\$2,600</u>	
	Family Out-of-pocket maximum	\$2,000	0	\$4,900 <u>\$5,200</u>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$10<u></u>\$15	
Health care provider's	Other practitioner office visit	\$5		\$10 <u>\$15</u>	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Teete	Laboratory Tests	\$8		\$15	
Tests	X-rays and Diagnostic Imaging	\$8		<u>\$25\$30</u>	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Drugs to treat illness or	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%	
Outpatient services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$100	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Emergency mMedical transportation (including emergency and non-	\$30	х	\$75	х
attention	emergency)	\$5	~		~
_		¢Ο		\$10<u></u>\$15	
Hospital stay	Facility fee (e.g. hospital room) <u>for inpatient stay (including labor and</u> delivery, mental health, and substance use)	10%	Х	15%	Х
	Physician/surgeon fee	10%	×	15%	×
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$10<u></u>\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		<u>\$10<u>\$15</u></u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Holp	Outpatient Rehabilitation and Habilitation services	\$5		<u>\$10\$15</u>	
Help recovering or			х		~
other special health needs	Skilled nursing care	10%	X	15%	Х
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
und of o care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	.			
and	Sealants per Tooth	No charge		No charge	
Preventive	' Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				

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ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPI	_
ctuarial Value - A	V Calculator	73.9%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	/ *0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 / \$130<u>\$</u>175 \$4,400 / \$260<u>\$</u>350	
	Individual Out-of-pocket maximum	\$5,850 <u>\$6,300</u>	, φο
	Family Out-of-pocket maximum	<u>\$11,700\$12,600</u>	<u>)</u>
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$30<u>\$35</u>	
Health care provider's	Other practitioner office visit	\$30<u></u>\$35	
office or clinic visit	Specialist visit	\$75	
lon	Preventive care/ screening/ immunization		
	Laboratory Tests	No charge \$35	
Tests		\$75	
	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		
		\$300	Pharma
	Tier 1	\$15	deductib
Drugs to treat	Tier 2	\$50	Pharma deductit
Iness or condition	Tier 3	\$75	Pharma
			deductit
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductit
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
501 11005	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Emergency mMedical transportation (including emergency and non-	\$250	х
	<u>emergency)</u> Urgent care	\$30 \$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	20%	Х
	Physician/surgeon fee	20%	×
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$30 <u>\$35</u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30<u></u>\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	<u>\$30\$35</u>	
recovering or	Skilled nursing care	20%	x
other special nealth needs		20%	~
	Durable medical equipment		
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child		50%	

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	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Bronze Plar	,	Bronze	
ctuarial Value - A	·	60.8%60.9%		HDHP Pla 61.4%61.0	
iciuariai value - A	Plan design includes a deductible?		-		
	Integrated Individual deductible	Yes, Medical/Pha N/A	rmacy	Yes, integra \$4,800 <u>\$6,000</u> in	
	Integrated Family deductible	N/A		\$9,600<u></u>\$12,000 ii	ntegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 /	\$0	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000) / \$0	N/A	
	Individual Out–of–pocket maximum	\$ 7,000<u>\$7,55</u>0	_	\$ 6,550<u>\$6,</u>6	
	Family Out-of-pocket maximum	\$14,000\$ <u>15,1</u>	<u>00</u>	\$13,100 <u>\$13</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		\$4,800<u>\$6,(</u> \$4,800<u>\$6,(</u>	
Common	Service Type	Member Cost Share	Deductible Applies	Member Cost	Deductible
Medical Event	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-	Share 40%	Applies X
Health care provider's	Other practitioner office visit	\$75	preventive visits After 1st three non- preventive visits	40%	x
office or clinic visit	Specialist visit	\$105	After 1st three non-	40%	x
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge	
	Laboratory Tests	\$40		40%	x
Tests	X-rays and Diagnostic Imaging	100%	Х	40%	x
	Imaging (CT/PET scans, MRIs)	100%	X	40%	x
		100% up to \$500 per script after	Pharmacy	40% 40% up to \$500	
	Tier 1	pharmacy deductible	Deductible	per script	X
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	x
llness or condition	Tier 3	100% up to \$500 per script	Pharmacy	40% up to \$500	x
		after pharmacy deductible 100% up to \$500 per script	Deductible Pharmacy	per script 40% up to \$500	
	Tier 4	after pharmacy deductible	Deductible	per script	Х
	Surgery facility fee (e.g., ASC)	100%	х	40%	Х
Dutpatient services	Physician/surgeon fees	100%	х	40%	х
	Outpatient visit	100%	х	40%	х
	Emergency room facility fee (waived if admitted)	100%	х	40%	х
Need immediate	Emergency room physician fee (waived if admitted)	No charge		0%	х
mmediate Ittention	Emergency mMedical transportation (including emergency and non- emergency)	100%	х	40%	х
	Urgent care	\$75	After 1st three non- preventive visits	40%	х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100%	X	40%	x
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	100%	X	40%	x
		10070		-1070	X
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$75	After 1st three non- preventive visits	40%	Х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$75	х	40%	х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	100%	Х	40%	х
Help	Outpatient Rehabilitation and Habilitation services	\$75		40%	x
ecovering or other special	Skilled nursing care	100%	Х	40%	x
nealth needs	Durable medical equipment	100%	X	40%	x
	Hospice service	No charge		0%	x
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	ite enalge		i to onalgo	
	Preventive - Cleaning				
Child Dental	Preventive - Cleaning Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	•				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics	5001		F001	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
Child	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

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ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Catas	rophic Plan
ctuarial Value - A			
	Plan design includes a deductible?	103,	integrated
	Integrated Individual deductible		<u>,900</u> integrated
	Integrated Family deductible	<u>\$14,700<u>\$1</u></u>	5,800 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	¢7.	N/A
	Individual Out–of–pocket maximum		350 <u>\$7,900</u>
	Family Out-of-pocket maximum		200 <u>\$15,800</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no
Health care provider's	Other practitioner office visit	0%	preventive visits After 1st three no preventive visits
office or clinic visit	Specialist visit	0%	X
VISIC			~
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Fests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	Х
	Tier 1	0%	х
Drugs to treat	Tier 2	0%	х
condition	Tier 3	0%	х
	Tier 4	0%	х
	Surgery facility fee (e.g., ASC)	0%	х
Outpatient services	Physician/surgeon fees	0%	х
Services	Outpatient visit	0%	х
	Emergency room facility fee (waived if admitted)	0%	х
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate	Emergency mMedical transportation (including emergency and non-		X
attention	emergency)	0%	X After 1st three no
	Urgent care	0%	preventive visit
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	Х
Hospital stay	Physician/surgeon fee	0%	х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visit
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	x
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	Х
ecovering or other special	Skilled nursing care	0%	Х
nealth needs	Durable medical equipment	0%	х
	Hospice service	0%	х
	' Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	х
	Oral Exam	070	~
	Preventive - Cleaning		
Child Dental	Preventive - X-ray	No charge	
Diagnostic	······	NU charge	
Diagnostic and	Sealants per Tooth	No charge	
Diagnostic and		No charge	
Diagnostic and	Sealants per Tooth	NO GIAIGE	
Diagnostic and Preventive Child Dental	Sealants per Tooth Topical Fluoride Application		
Diagnostic and Preventive Child Dental Basic	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	0%	x
Diagnostic and Preventive Child Dental Basic	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures		X
Diagnostic and Preventive Child Dental Basic	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services		x
Diagnostic and Preventive Child Dental Basic Services Child Dental	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	0%	
Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)		x
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	0%	

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lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance		Platinum Copay Pla	
ctuarial Value - A	V Calculator	91.2%91.7		88.1%88.9	
	Plan design includes a deductible?				
	Integrated Individual deductible	No \$0		No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$	
	Individual Out–of–pocket maximum	\$3,350		\$3,350	
	Family Out-of-pocket maximum	\$6,700		\$6,700	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
				No charge	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$15		\$15	
Fests	X-rays and Diagnostic Imaging	\$15		\$15	
0010		\$30 10%			
	Imaging (CT/PET scans, MRIs)			\$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	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
501 41005	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-				
attention	emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
Help recovering or				\$15 \$150 per day up to	
other special health needs	Skilled nursing care	10%		5 days	
nearth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic		Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not Covered		Not Covered	
Basic Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance	Plan	Gold Copay Pla	ın
ctuarial Value - A	V Calculator	81.8%		78.4% 78.1	%
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Individual Out–of–pocket maximum	\$6,000 <u>\$7,20</u>	<u>00</u>	\$6,000<u>\$7,2</u>	00
	Family Out-of-pocket maximum	\$12,000<u>\$14,</u>4	<u>400</u>	\$12,000<u>\$14,</u>	400
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$25<u>\$</u>30		\$25<u>\$</u>30	
Health care provider's office or clinic	Other practitioner office visit	<u>\$25\$30</u>		<u>\$25\$30</u>	
visit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35		\$35	
Tests	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
illness or	T 0			A	
condition	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
361 11063	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate	Emergency mMedical transportation (including emergency and non-				
attention	emergency)	\$250		\$250	
	Urgent care	<u>\$25\$30</u>		\$ <u>25</u> \$ <u>30</u>	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%		\$600 per day up to 5 days	
····,	Physician/surgeon fee	20%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	<u>\$25\$30</u>		<u>\$25\$30</u>	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<u>\$25\$30</u>		<u>\$25\$30</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services	<u>\$25\$30</u>		<u>\$25\$30</u> \$300 per day up to	
other special	Skilled nursing care	20%		5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
and Freventive					
	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Restorative Procedures	Not Covered		Not Covered	
	Periodontal Maintenance Services				
	Periodontal Maintenance Services Crowns and Casts				
Basic Services					
Basic Services	Crowns and Casts	Not Covered		Not Covered	
Basic Services	Crowns and Casts Endodontics	Not Covered		Not Covered	
Child Dental Basic Services Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance)	Not Covered		Not Covered	

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lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan	
ctuarial Value - A	V Calculator	71.9% 71.8%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500/ \$130<u></u>\$200 /	\$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ <u>\$260</u> \$400 /	\$0
	Individual Out–of–pocket maximum	\$7,000<u>\$7,550</u>	
	Family Out-of-pocket maximum	\$14,000 <u>\$15,100</u>	<u>!</u>
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35<u>\$40</u>	
Health care provider's office or clinic	Other practitioner office visit	<u>\$35\$40</u>	
/isit	Specialist visit	\$ 75 <u>\$80</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Fests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharmac deductibl
Drugs to treat	Tier 2	\$55	Pharmad
llness or			deductibl Pharmad
condition	Tier 3	\$80	deductibl
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductibl
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)		
Need		\$350	
immediate	Emergency room physician fee (waived if admitted) Emergency mMedical transportation (including emergency and non-	No charge	
attention	emergency)	\$250	Х
	Urgent care	<u>\$35\$40</u>	
lless affects of a second	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х
Hospital stay	Physician/surgeon fee	20%	×
Mental health,	Mental/behavioral health and substance use disorder outpatient office	<u>\$35\$40</u>	
behavioral health, or	visits	\$00 <u>\$40</u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$ <u>35</u> <u>\$40</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
regnancy		-	
	Home health care (cost share per visit)	\$45	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$40</u>	
other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic	Sealants per Tooth	Not Covered	
and Preventive			
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services		
	Crowns and Casts		
	Endodontics		
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		

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-	nefits and Coverage	CCSB Silver		CCSB Silver	
Iember Cost Share amounts describe the Enrollee's out of pocket costs.		Coinsurance Plan	1	Copay Plan	
ctuarial Value - A	V Calculator	71.9%		71.4% 71.6%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$125<u></u>\$200 /		\$2,000 / \$125<u></u>\$200 .	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / <u>\$250</u> \$400 /	\$0	\$4,000 / <u>\$250</u> \$400	/ \$0
	Individual Out–of–pocket maximum			\$ 7,000 <u>\$7,550</u> \$14,000 <u>\$15,100</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible			914,000 <u>913,100</u> N/A	<u>.</u>
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib 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	<u>\$75\$80</u>		<u>\$75<u>\$80</u></u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$70<u>\$75</u>		\$70<u>\$75</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	\$15	Pharmacy deductible	\$15	Pharma deductib
	Tier 2	\$55	Pharmacy	\$55	Pharma
Drugs to treat illness or		ψου	deductible	ψου	deductit
condition	Tier 3	\$85	Pharmacy deductible	\$85	Pharma deductit
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharma deductik
	Surgery facility fee (e.g., ASC)	20%	doddolbio	20%	acado
Outpatient	Physician/surgeon fees	20%		20%	
services		20%			
				20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need immediate	Emergency room physician fee (waived if admitted) Emergency mMedical transportation (including emergency and non-	No charge		No charge	
attention	emergency	\$250	Х	\$250	х
	Urgent care	\$45		\$45	
	Facility fee (e.g. hospital room) <u>for inpatient stay (including labor and</u> delivery, mental health, and substance use)	20%	Х	20%	х
Hospital stay	Physician/surgeon fee	20%	х	20%	×
Mental health,	Mental/behavioral health and substance use disorder outpatient office				
behavioral	visits	\$45		\$45	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$45		\$45	
abuse needs	items and services	ψ η υ		ψ τ υ	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$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	
	- Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam			. to sharge	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not Covered		Not Covered	
Basic Services	Periodontal Maintenance Services			Hot obvorou	
	Crowns and Casts				
	Endodontics				
	Endodontics Periodontics (other than maintenance)	Not Covered		Not Covered	
Child Dental Major Services		Not Covered		Not Covered	
	Periodontics (other than maintenance)	Not Covered		Not Covered	

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-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB Silver HDHP PI	
ctuarial Value - A	V Calculator	71.7% 70.	
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$ 2,000 \$2,500	
	Integrated Family deductible	\$4,000<u>\$5,000</u> ii	ntegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$ <u>6,550</u> \$6,	
	Family Out-of-pocket maximum	\$ 13,100<u>\$13</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$2,000<u>\$2,</u> \$2,700 See e	
Common Medical Event	Service Type	Member Cost Share	Deductible
	Primary care visit to treat an injury, illness, or condition	20%	Applies
Health care	Thinary care visit to treat an injury, illness, or condition	2076	^
provider's office or clinic	Other practitioner office visit	20%	Х
visit	Specialist visit	20%	х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	Х
Tests	X-rays and Diagnostic Imaging	20%	х
	Imaging (CT/PET scans, MRIs)	20%	х
	Tier 1	20% up to \$250 per	х
	nor i	script	~
Drugs to treat	Tier 2	20% up to \$250 per script	х
llness or condition	Tier 3	20% up to \$250 per script	х
	Tier 4	20% up to \$250 per script	х
	Surgery facility fee (e.g., ASC)	20%	х
Outpatient services	Physician/surgeon fees	20%	х
	Outpatient visit	20%	х
	Emergency room facility fee (waived if admitted)	20%	х
Need	Emergency room physician fee (waived if admitted)	0%	х
mmediate	Emergency mMedical transportation (including emergency and non-	20%	x
attention	<u>emergency)</u> Urgent care	20%	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	20%	Х
	Physician/surgeon fee	20%	Х
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	20%	х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	х
Help	Outpatient Rehabilitation and Habilitation services	20%	х
recovering or		20%	x
other special health needs	Skilled nursing care		
	Durable medical equipment	20%	X
	Hospice service	0%	Х
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray	Not Courses !	
Diagnostic and Preventive	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dentel	' Restorative Procedures		
Child Dental Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Dental			
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

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lember Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
ctuarial Value - A	V Calculator	93.9% 94.		88.0% <u>87.9%</u>	-
	Plan design includes a deductible?			Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	nannacy	N/A	lacy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$1,300 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$1,000)	\$2,450<u></u>\$2,600	
	Family Out-of-pocket maximum	\$2,000)	\$4,900<u>\$5,200</u>	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		<u>\$10\$15</u>	
Health care provider's	Other practitioner office visit	\$5		<u>\$10\$15</u>	
office or clinic visit	Specialist visit	01		¢QE	
lisit	Specialist visit	\$8		\$25	
_	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$8 \$8		\$15	
0313		\$8 \$50		\$25<u>\$</u>30 \$100	
	Imaging (CT/PET scans, MRIs)				
	Tier 1	\$3		\$5	
Drugs to treat illness or	Tier 2	\$10		\$20	Pharmac deductibl
condition	Tier 3	\$15		\$35	Pharmac deductibl
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmac deductibl
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
501 11005	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$100	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Emergency mMedical transportation (including emergency and non-	\$30	х	\$75	x
	<u>emergency)</u> Urgent care	\$5		\$10 \$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%	X X	15%	× ×
		1070	X	1070	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		<u>\$10\$15</u>	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		<u>\$10\$15</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5		<u>\$10<u></u>\$15</u>	
other special health needs	Skilled nursing care	10%	Х	15%	Х
nearth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
eye ouro	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Oral Exam Preventive - Cleaning				
		Not Coursed		Not Coursed	
Diagnostic	Preventive - Cleaning	Not Covered		Not Covered	
Diagnostic	Preventive - Cleaning Preventive - X-ray	Not Covered		Not Covered	
Diagnostic	Preventive - Cleaning Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered	
Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application				
Diagnostic and Preventive Child Dental	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Diagnostic and Preventive Child Dental	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures				
Diagnostic and Preventive Child Dental Basic Services	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services				
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts				
Diagnostic and Preventive Child Dental Basic Services	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	Not Covered		Not Covered	
Diagnostic and Preventive Child Dental Basic Services Child Dental	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)	Not Covered		Not Covered	

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

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan	
Actuarial Value - A	·	200%-250% FPI 73.9%	-
iciuariai value - A	Plan design includes a deductible?		
	Integrated Individual deductible	Yes, Medical/Pharm N/A	lacy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 / \$130<u></u>\$175	/ \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,400 / <u>\$260\$350</u>	/ \$0
	Individual Out-of-pocket maximum	\$5,850<u>\$6,300</u>	
	Family Out-of-pocket maximum	\$11,700<u></u>\$12,600	!
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$30<u></u>\$35	
provider's	Other practitioner office visit	\$30<u></u>\$35	
visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Tests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharma
	Tite 0		deductib Pharma
Drugs to treat illness or	Tier 2	\$50	deductib
condition	Tier 3	\$75	Pharma deductib
	Tier 4	20% up to \$250 per script	Pharma
	Tier 4	after pharmacy deductible	deductib
0 (1) (1)	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Emergency mMedical transportation (including emergency and non-	\$250	х
	<u>emergency)</u> Urgent care	\$30 \$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		X
Hospital stay	delivery, mental health, and substance use)	20%	Х
Mental health,	Physician/surgeon fee Mental/behavioral health and substance use disorder outpatient office	20%	.X
behavioral health, or	visits	<u>\$30<u>\$35</u></u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<u>\$30\$35</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Holp	Outpatient Rehabilitation and Habilitation services	<u>\$30\$35</u>	
Help recovering or		20%	х
other special health needs	Skilled nursing care		~
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray	Not Covered	
Diagnostic and Preventive	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental		Net O	
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

20182019 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 15, 2017March 15, 2018

Actuarial Value - AV Calculator 60.8%60.9% 61.4 Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Integrated Individual deductible N/A \$4,800 <u>\$60</u> Integrated Individual deductible N/A \$9,600 <u>\$12</u> Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$6,300 / \$500 / \$0 \$9 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$12,600 / \$1,000 / \$0 \$6,50 Individual Out-of-pocket maximum \$7,900 <u>\$7,550</u> \$6,50 Family Out-of-pocket maximum \$14,000\$15,100 \$13,40	ize
Profit description Ves. Mcdcail Ves. Mcdcail Ves. Mcdcail Ves. Mcdcail Ves. Mcdcail Integrated inductation MA MA <t< td=""><td>Plan 1.6%</td></t<>	Plan 1.6%
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H3A langupanent index and index	13,300
Common Medical Event Service Type Member Cost Share Description Applies Member Cost Share Member Cost Share Member Cost Share Health care providers Firmary care visits to trant an injury, liness, or candition 375 Airr 1st lines on preventive visits 40% One practitioner office visit One state and preventive visits 575 Airr 1st lines on preventive visits 40% Tests Becident visit No charge 40% 40% Tests State state and preventive visits No charge 40% Tests Test 1 100% up to S500 per script and preventive and bioprostic imaging (TFEET scams, MEIs) 100% up to S500 per script and preventive and bioprostic imaging (TFEET scams, MEIs) 40% 40% Outpatient visit Test 1 Test 2 100% up to S500 per script and preventive diversity of scale and preventive and preventive diversity	6,000
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services Projectanistry decinition frees Indow X 44% Outpatient visit Outpatient visit 100% X 40% Need immediate attentione Emergency room facility fee (waived if admitted) No charge 0% Emergency room physician fee (waived if admitted) No charge 0% Urgent care 757 After 1st three non- preventive visits 0% Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 100% X 40% Mental health, behavioral behavioral tems and services After 1st three non- preventive visits After 1st three non- preventive visits 40% Mental health, or substance Mental behavioral health and substance use disorder outpatient office visits S75 After 1st three non- preventive visits 40% Mental health, or substance Mental behavioral health and substance use disorder outpatient office visits S75 After 1st three non- preventive visits 40% Pregnancy Prenatal care and preconception visits No charge No charge 40% Heap recovering or citter special health needs Gudpatient Rehabilitation and Habilitation services S75 After 1st three non- preventive visits 40% Child eye care Gudpatient Rehabilitation and Habilitation services S75 No charge <t< td=""><td>X</td></t<>	X
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immediate attention immediate mergency Medical transportation (including emergency and non- grading emergency). Urgent care including emergency and non- grading emergency and non-	X
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Hospital stay delivery, mental health, and substance use) 100% X 40% Physician/surgeon fee 100% X 40% Mental health, or substance Mental/behavioral health and substance use disorder outpatient office substance \$75 After 1st three non- preventive visits 40% Pregnancy Prenatal care and preconception visits No charge X 40% Help other special health nor substance Mone health care (cost share per visit) No charge No charge No charge Intervention Stilled nursing care 100% X 40% Outpatient Rehabilitation and Habilitation services No charge No charge 0% Child ever for pervisit 100% X 40% The special health need 100% X 40% Child ever for pervisit 100% X 40% Child ever for pervisit Strip Mone halth 40% The special health need Strip X 40% Pregnancy Ever sam No charge 10% Child ever for pervise Strip No charge No charge Interventive -	Х
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behavioral heth, or substance visits preventive visits preventive visits 44% Mental/behavioral health and substance use disorder other outpatient substance \$75 X 40% Pregnancy Frenatal care and preconception visits No charge No charge No charge Help recovering or other special enalth need More health care (cost share per visit) 100% X 40% Skilled nursing care 0upatient Rehabilitation and Habilitation services \$75 S 40% Durable medical equipment 100% X 40% Hong ice service No charge 0% 40% Child eye and Silled nursing care No charge 0% The of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Not Covered Not Covered	x
behavioral health, or substance abuse needs Visits Preventive visits Preventive visits Mental/behavioral health and substance use disorder other outpatient items and services \$75 X 40% Pregnancy Prenatal care and preconception visits No charge No charge No charge Help recovering or other special health needs Outpatient Rehabilitation and Habilitation services \$75 X 40% Skilled nursing care 0utpatient Rehabilitation and Habilitation services \$75 X 40% Outpatient Rehabilitation and Habilitation services \$75 X 40% Durable medical equipment 100% X 40% Inair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Child Dental Diagnostic Cral Exam No charge No charge Preventive - Cleaning Not Covered Not Covered Not Covered	x
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Addise needs Items and services Items and services Items and services No charge No charge Pregnancy Prenatal care and preconception visits No charge No charge No charge No charge Help recovering or other special health needs Home health care (cost share per visit) 100% X 40% Skilled nursing care 100% X 40% 40% 40% Durable medical equipment 100% X 40%	x
Help recovering or other special health needs Home health care (cost share per visit) 100% X 40% Outpatient Rehabilitation and Habilitation services \$75 40% 40% Skilled nursing care 100% X 40% Durable medical equipment 100% X 40% Home health needs 100% X 40% Preventive Skilled nursing care 0% 0% Durable medical equipment 100% X 40% Home health needs Skilled nursing care 0% 0% Preventive Seg exam No charge 0% 0% Oral Exam Preventive - Cleaning No charge No charge No charge Preventive - X-ray Sealants per Tooth Not Covered Not Covered Not Covered	~
Help recovering of ther special health needs Outpatient Rehabilitation and Habilitation services \$75 40% Skilled nursing care 100% X 40% Durable medical equipment 100% X 40% Hospice service 00 charge 0% Child eye care Eye exam No charge 0% 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Oral Exam Preventive - Cleaning Preventive - Cleaning Not Covered Not Covered Not Covered	
recovering or other special health needs Skilled nursing care 100% X 40% Durable medical equipment 100% X 40% Hospice service No charge 0% Child eye care Eye exam No charge 0% 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Oral Exam Preventive - Cleaning Preventive - Cleaning Not Covered Not Covered Not Covered	X
other special health needs Skilled nursing care 100% X 40% Durable medical equipment 100% X 40% Hospice service No charge 0% Child eye care Eye exam No charge 0% 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Oral Exam Preventive - Cleaning Preventive - Cleaning Not Covered Not Covered Not Covered	X
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Diagnostic and Preventive Not Covered Not Covered	
Diagnostic and Preventive Not Covered Not Covered	
Space Maintainers - Fixed	
Posterative Breadway	
Child Dental Resolutive Procedures Not Covered Not Covered Basic Services Periodontal Maintenance Services Not Covered Not Covered	
Crowns and Casts	
Endodontics	
Child Dental Periodontics (other than maintenance) Not Covered Not Covered	
Major Services	
Prosthodontics	
Child Nr. 1 Andrew Child	
Orthodontics Medically necessary orthodontics Not Covered Not Covered	

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-	nefits and Coverage		
lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	trophic Plan
ctuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$7,350<u>\$7</u>	,900 integrated
	Integrated Family deductible	tible \$14,700 <u>\$15,800</u> integrat	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	\$7,3	350\$7,900
	Family Out-of-pocket maximum	\$14,7	200<u>\$15,800</u>
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
Health care	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no preventive visits
provider's	Other practitioner office visit	0%	After 1st three no preventive visits
visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	х
Drugs to treat	Tier 2	0%	x
Ilness or condition	Tier 3	0%	x
onation		U%	Ă
	Tier 4	0%	х
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient services	Physician/surgeon fees	0%	х
services	Outpatient visit	0%	х
	Emergency room facility fee (waived if admitted)	0%	х
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate	Emergency mMedical transportation (including emergency and non-	0%	x
attention	emergency)		After 1st three no
		0%	preventive visit
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	Х
,	Physician/surgeon fee	0%	х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	x
abuse needs	items and services	078	~
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Help	Outpatient Rehabilitation and Habilitation services	0%	х
ecovering or	Skilled nursing care	0%	x
other special health needs	Durable medical equipment	0%	x
	Hospice service	0%	Х
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental	Periodontics (other than maintenance)	Not Covered	
Major Services	, ,	INOL COVERED	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

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

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

Notes:

- 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.
- For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2019 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code\$2,700 for Plan Year 2018. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$200 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California <u>2017-2019</u> Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a

service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs;
2	2) Preferred brand name drugs; and
	3) Any other drugs recommended by the plan's
	pharmaceutical and therapeutics (P&T) committee based on
	drug safety, efficacy and cost.
	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based
3	on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	1) Drugs that are biologics and drugs that the Food and
4	Drug Administration (FDA) or drug manufacturer requires to
	be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or
	clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than
	six hundred dollars (\$600) net of rebates for a one-month
	supply.

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.