2017 Standard Benefit Plan Designs

~~April 7, 2016~~ June 16, 2016

~~Final Board-approved~~

Revised for Board Review and Action

2017 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 7, 2016~~ June 16, 2016

COVERED CALIFORNIA™

Summary of Benefits and Coverage

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

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	89.7%	90.3%
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	$4,000	$4,000
Family Out-of-pocket maximum	$8,000	$8,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$15		$15	
	Other practitioner office visit		$15		$15	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Tier 1		$5		$5	
	Tier 2		$15		$15	
	Tier 3		$25		$25	
	Tier 4		10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%		$40	
	Outpatient visit		10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$150		$150	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$150		$150	
	Urgent care		$15		$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%		$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$15		$15	
	Mental/Behavioral health other outpatient items and services		$15		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		10%		$40	
	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%		$40	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		$40	
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$15		$15	
	Outpatient Habilitation services		$15		$15	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

2017 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

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

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.9%	81.2%
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	$6,750	$6,750
Family Out-of-pocket maximum	$13,500	$13,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30		$30	
	Other practitioner office visit		$30		$30	
	Specialist visit		$55		$55	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$35		$35	
	X-rays and Diagnostic Imaging		$55		$55	
	Imaging (CT/PET scans, MRIs)		20%		$275	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55		$55	
	Tier 3		$75		$75	
	Tier 4		20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%		$55	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$325		$325	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250		$250	
	Urgent care		$30		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%		$55	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30		$30	
	Mental/Behavioral health other outpatient items and services		$30		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		20%		$55	
	Substance Use disorder outpatient office visits		$30		$30	
	Substance Use disorder other outpatient items and services		$30		$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%		$55	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%		$55	
Help recovering or other special health needs	Home health care		20%		$30	
	Outpatient Rehabilitation services		$30		$30	
	Outpatient Habilitation services		$30		$30	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

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10.0 EHB
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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	Individual Silver Plan
Actuarial Value - AV Calculator	71.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000/ $500 / $0
Individual Out–of–pocket maximum	$6,800
Family Out-of-pocket maximum	$13,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$35	
	Other practitioner office visit		$35	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$70	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$55	Pharmacy deductible
	Tier 3		$80	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$35	
	Mental/Behavioral health other outpatient items and services		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$35	
	Substance Use disorder other outpatient items and services		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$45	
	Outpatient Rehabilitation services		$35	
	Outpatient Habilitation services		$35	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

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10.0 EHB
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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver Coinsurance Plan	CCSB Silver Copay Plan
Actuarial Value - AV Calculator	71.6%	71.3%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,000/ $250 / $0	$2,000/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,000 / $500 / $0	$4,000 / $500 / $0
Individual Out–of–pocket maximum	$6,800	$6,800
Family Out-of-pocket maximum	$13,600	$13,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$45		$45	
	Other practitioner office visit		$45		$45	
	Specialist visit		$75		$75	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		$40	
	X-rays and Diagnostic Imaging		$70		$70	
	Imaging (CT/PET scans, MRIs)		20%		$300	
Drugs to treat illness or condition	Tier 1		$15		$15	
	Tier 2		$55	Pharmacy deductible	$55	Pharmacy deductible
	Tier 3		$85	Pharmacy deductible	$85	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
	Outpatient visit		20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350		$350	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$45		$45	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$45		$45	
	Mental/Behavioral health other outpatient items and services		$45		$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X	20%	X
	Mental/Behavioral health inpatient physician fee		20%	X	20%	X
	Substance Use disorder outpatient office visits		$45		$45	
	Substance Use disorder other outpatient items and services		$45		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Substance use disorder inpatient physician fee		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		See 2017 Dental Copay Schedule	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		$1,000	

See endnotes.

2017 Standard Benefit Plan Designs
10.0 EHB
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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver HDHP Plan
Actuarial Value - AV Calculator	71.3%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	~~$6,650~~ $6,550
Family Out-of-pocket maximum	~~$13,300~~ $13,100
HSA plan: Self-only coverage deductible	$2,000
HSA family plan: Individual deductible	$2,600

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

See endnotes.

2017 Standard Benefit Plan Designs
10.0 EHB
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Summary of Benefits and Coverage

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

	Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.1%	87.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$75 / $0 / $0	$650 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$150 / $0 / $0	$1,300 / $100 / $0
Individual Out–of–pocket maximum	$2,350	$2,350
Family Out-of-pocket maximum	$4,700	$4,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$5		$10	
	Other practitioner office visit		$5		$10	
	Specialist visit		$8		$25	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$8		$15	
	X-rays and Diagnostic Imaging		$8		$25	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Tier 1		$3		$5	
	Tier 2		$10		$20	Pharmacy deductible
	Tier 3		$15		$35	Pharmacy deductible
	Tier 4		10% up to $150 per script		15% up to $150 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$50		$100	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$30	X	$75	X
	Urgent care		$5		$10	
Hospital stay	Facility fee (e.g. hospital room)		10%	X	15%	X
	Physician/surgeon fee		10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$5		$10	
	Mental/Behavioral health other outpatient items and services		$5		$10	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	X	15%	X
	Mental/Behavioral health inpatient physician fee		10%	X	15%	X
	Substance Use disorder outpatient office visits		$5		$10	
	Substance Use disorder other outpatient items and services		$5		$10	
	Substance Use inpatient facility fee (e.g. hospital room)		10%	X	15%	X
	Substance use disorder inpatient physician fee		10%	X	15%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care		$3		$15	
	Outpatient Rehabilitation services		$5		$10	
	Outpatient Habilitation services		$5		$10	
	Skilled nursing care		10%	X	15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge		No charge	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		20%		20%	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		50%		50%	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		50%		50%	

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

	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,200 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,400 / $500 / $0
Individual Out–of–pocket maximum	$5,700
Family Out-of-pocket maximum	$11,400
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30	
	Other practitioner office visit		$30	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$65	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$50	Pharmacy deductible
	Tier 3		$75	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30	
	Mental/Behavioral health other outpatient items and services		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$30	
	Substance Use disorder other outpatient items and services		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$30	
	Outpatient Habilitation services		$30	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		No charge	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		20%	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		50%	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		50%	

See endnotes.

2017 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.9%	62.0%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	~~$4,500~~ $4,800 integrated
Integrated Family deductible	N/A	~~$9,000~~ $9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,300 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$12,600 / $1,000 / $0	N/A
Individual Out–of–pocket maximum	$6,800	~~$6,650~~ $6,550
Family Out-of-pocket maximum	$13,600	~~$13,300~~ $13,100
HSA plan: Self-only coverage deductible	N/A	~~$4,500~~ $4,800
HSA family plan: Individual deductible	N/A	~~$4,500~~ $4,800

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

See endnotes.

2017 Standard Benefit Plan Designs
10.0 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$7,150 integrated
Integrated Family deductible	$14,300 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$7,150
Family Out-of-pocket maximum	$14,300
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

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

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

COVERED CALIFORNIA™

Summary of Benefits and Coverage

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

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	89.7%	90.3%
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	$4,000	$4,000
Family Out-of-pocket maximum	$8,000	$8,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$15		$15	
	Other practitioner office visit		$15		$15	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Tier 1		$5		$5	
	Tier 2		$15		$15	
	Tier 3		$25		$25	
	Tier 4		10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%		$40	
	Outpatient visit		10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$150		$150	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
	Emergency medical transportation		$150		$150	
	Urgent care		$15		$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%		$40	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$15		$15	
	Mental/Behavioral health other outpatient items and services		$15		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		10%		$40	
	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%		$40	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		$40	
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$15		$15	
	Outpatient Habilitation services		$15		$15	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

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

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.9%	81.2%
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	$6,750	$6,750
Family Out-of-pocket maximum	$13,500	$13,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

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

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan
Actuarial Value - AV Calculator	71.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000/ $500 / $0
Individual Out–of–pocket maximum	$6,800
Family Out-of-pocket maximum	$13,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$35	
	Other practitioner office visit		$35	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$70	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$55	Pharmacy deductible
	Tier 3		$80	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$35	
	Mental/Behavioral health other outpatient items and services		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$35	
	Substance Use disorder other outpatient items and services		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$45	
	Outpatient Rehabilitation services		$35	
	Outpatient Habilitation services		$35	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver Coinsurance Plan	CCSB Silver Copay Plan
Actuarial Value - AV Calculator	71.6%	71.3%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,000/ $250 / $0	$2,000/ $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,000 / $500 / $0	$4,000 / $500 / $0
Individual Out–of–pocket maximum	$6,800	$6,800
Family Out-of-pocket maximum	$13,600	$13,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

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

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	CCSB Silver HDHP Plan
Actuarial Value - AV Calculator	71.3%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	~~$6,650~~ $6,550
Family Out-of-pocket maximum	~~$13,300~~ $13,100
HSA plan: Self-only coverage deductible	$2,000
HSA family plan: Individual deductible	$2,600

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

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

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

	Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.1%	87.5%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$75 / $0 / $0	$650 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$150 / $0 / $0	$1,300 / $100 / $0
Individual Out–of–pocket maximum	$2,350	$2,350
Family Out-of-pocket maximum	$4,700	$4,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

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

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

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

	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,200 / $250 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,400 / $500 / $0
Individual Out–of–pocket maximum	$5,700
Family Out-of-pocket maximum	$11,400
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition		$30	
	Other practitioner office visit		$30	
	Specialist visit		$55	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$65	
	Imaging (CT/PET scans, MRIs)		$300	
Drugs to treat illness or condition	Tier 1		$15	
	Tier 2		$50	Pharmacy deductible
	Tier 3		$75	Pharmacy deductible
	Tier 4		20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		$350	
	Emergency room physician fee (waived if admitted)		No charge	
	Emergency medical transportation		$250	X
	Urgent care		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30	
	Mental/Behavioral health other outpatient items and services		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$30	
	Substance Use disorder other outpatient items and services		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$30	
	Outpatient Habilitation services		$30	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.9%	62.0%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	~~$4,500~~ $4,800 integrated
Integrated Family deductible	N/A	~~$9,000~~ $9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$6,300 / $500 / $0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$12,600 / $1,000 / $0	N/A
Individual Out–of–pocket maximum	$6,800	~~$6,650~~ $6,550
Family Out-of-pocket maximum	$13,600	~~$13,300~~ $13,100
HSA plan: Self-only coverage deductible	N/A	~~$4,500~~ $4,800
HSA family plan: Individual deductible	N/A	~~$4,500~~ $4,800

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

See endnotes.

2017 Standard Benefit Plan Designs
9.5 EHB
Date: ~~April 7, 2016~~ June 16, 2016

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$7,150 integrated
Integrated Family deductible	$14,300 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$7,150
Family Out-of-pocket maximum	$14,300
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

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

See endnotes.

Endnotes to 2017 Standard Benefit Plan Designs

These endnotes and the Standard Benefit Plan Designs apply only to covered services.

Notes:

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.
2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $~~X,XXX~~2,600[1] for Plan Year 2017. 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 Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
8) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month per state law.
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.

~~[1] The minimum deductible amount for high-deductible health plans will be the 2017 inflation-adjusted amount determined by the IRS pursuant to section 223(c)(2)(A) of the Internal Revenue Code for other than self-only coverage.~~

11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2017 Dental Copay Schedule.
13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard 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.
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 specialist for a service provided by one of these practitioners.
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 standard benefit plan designs if necessary for compliance with MHPAEA.
22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
23) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >$600.

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.