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

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

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

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

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



Member Cost S	Platinum		Platinum			
Actuarial Value	Coinsurance Plan 91.2%		Copay Plan 88.1%			
	cludes a deductible?		No.	•	No	
Integrated Inc	dividual deductible		\$0		\$0	
	ımily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$0 \$0 / \$0 / \$0		\$0 \$0 / \$0 /	\$0
Family deduc	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum				\$0 / \$0 / \$0 \$3,350	
Family Out-of-	pocket maximum		\$3,35 \$6,70		\$6,700	
HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A		N/A N/A		
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$15		\$15	
Health care provider's office or clinic visit	Other practitioner office visit		\$15		\$15	
Violi	Specialist visit		\$30		\$30	
	Preventive care/ screening/ im Laboratory Tests	munization	No charge \$15		No charge \$15	
Tests	X-rays and Diagnostic Imaging		\$30		\$30	
	Imaging (CT/PET scans, MRIs		10%		\$75	
	Tier 1		\$5		\$5	
Drugs to treat illness or	Tier 2		\$15		\$15	
condition	Tier 3		\$25		\$25	
	Tier 4 Surgery facility fee (e.g., ASC)		10% up to \$250 per script		10% up to \$250 per script \$100	
Outpatient services	Physician/surgeon fees		10%		\$25	
Services	Outpatient visit		10%		10%	
	Emergency room facility fee (w	aived if admitted)	\$150		\$150	
Need	Emergency room physician fee	(waived if admitted)	No charge		No charge	
immediate	Emergency medical transporta	tion	\$150		\$150	
attention	Urgent care		\$15		\$15	
	Facility fee (e.g. hospital room)		10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days No charge	
	<u> </u>	ental/Behavioral health outpatient office visits			\$15	
	Mental/Behavioral health other	\$15		\$15		
Mental health,	Mental/Behavioral health inpat	10%		\$250 per day up to 5 days		
behavioral	Mental/Behavioral health inpat	10%		No charge		
health, or substance abuse needs	Substance Use disorder outpa	\$15		\$15		
	Substance Use disorder other	\$15		\$15		
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%		\$250 per day up	
	Substance use disorder inpatie		10%		to 5 days No charge	
	Prenatal care and preconception		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up	
	services	Professional	10%		to 5 days No charge	
	Home health care (cost share		10%		\$20	
Help recovering or	Outpatient Rehabilitation services Outpatient Habilitation services		\$15 \$15		\$15 \$15	
other special	Skilled nursing care		10%		\$150 per day up	
health needs	Durable medical equipment		10%		to 5 days 10%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or co	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
Child Dental Diagnostic						
and Preventive	Sealants per Tooth Topical Fluoride Application	No charge		No charge		
Child Dental	Space Maintainers - Fixed				Can 2040 D	
Basic	Restorative Procedures		20%		See 2018 Dental Copay Schedule	
Services	Periodontal Maintenance Service Crowns and Casts	ces				
Child Dental	Endodontics				Soc 2010 D 1	
Major Services	Periodontics (other than mainte	enance)	50%		See 2018 Dental Copay Schedule	
30.71003	Prosthodontics Oral Surgery					
Child		ice	50%		¢1 000	
Orthodontics	Medically necessary orthodont	100	50%		\$1,000	

•	Benefits and Coverage hare amounts describe the Enr	ollee's out of nocket costs	Gold		Gold	
	- AV Calculator	oo o out or pooner costs.	Coinsuran 81.89		78.4%	
Plan design in	cludes a deductible?		No		No	
Integrated In	dividual deductible		\$0 \$0		\$0 \$0	
	imily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 \$0 / \$0 / \$0	
	ctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$0 / \$0 \$6,00		\$0 / \$0 / \$6,000	
	pocket maximum		\$12,00		\$12,00	
	-only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
TIOA lailing pla	iii. Ilidividdal deddctible		19/24		19/24	
Common Medical Event			Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in		\$25		\$25	
Health care	Other practitioner office visit		\$25		\$25	
office or clinic						
	Specialist visit  Preventive care/ screening/ im	munization	\$55 No charge		\$55 No charge	
	Laboratory Tests	munization	\$35		\$35	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$55 20%		\$55 \$275	
	Tier 1	)	\$15		\$275	
	Tier 2		\$55		\$55	
Drugs to treat illness or condition						
Condition	Tier 3		\$75		\$75	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20%		\$300 \$40	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (w	vaived if admitted)	\$325		\$325	
Nood	Emergency room physician fee	e (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transporta	tion	\$250		\$250	
attention	Urgent care		\$25		\$25	
Hospital stay	Facility fee (e.g. hospital room	)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health outpatient office visits		\$25		\$25	
	Mental/Behavioral health other	\$25		\$25		
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inpat	ient physician fee	20%		to 5 days No charge	
behavioral health, or	Wental Benavioral near input	ioni priyoloidir ioo	2070		140 charge	
substance abuse needs	Substance Use disorder outpa	tient office visits	\$25		\$25	
	Substance Use disorder other	outpatient items and services	\$25		\$25	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatie	ent physician fee	20%		No charge	
	Prenatal care and preconcepti	on visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up to 5 days	
	services	Professional	20%		No charge	
	Home health care (cost share Outpatient Rehabilitation servi		20% \$25		\$30 \$25	
Help recovering or	Outpatient Renabilitation service		\$25 \$25		\$25	
other special	Skilled nursing care		20%		\$300 per day up to 5 days	
health needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care		ontact lenses in lieu of glasses)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam				·	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		<b>.</b>			
and Preventive	Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures		20%		See 2018 Dental Copay Schedule	
Services	Periodontal Maintenance Serv Crowns and Casts	ices			, j = incadio	
Child Dental	Endodontics					
Major	Periodontics (other than maint	enance)	50%		See 2018 Dental Copay Schedule	
Services	Prosthodontics Oral Surgery					
Child	Medically necessary orthodon	ics	50%		\$1,000	
Orthodontics	y 1100033ai y 01tii10d0III		3070		ψ1,000	

# 2018 Patient-Centered Benefit Plan Designs 10.0 EHB

Summary of	Benefits and Coverage		Individua	l
Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan	ı
Actuarial Value	- AV Calculator		71.9%	
	cludes a deductible?		Yes, Medical/Pha	armacy
Integrated Fa	dividual deductible mily deductible		N/A N/A	
	ductible, NOT integrated: Me tible, NOT integrated: Medic		\$2,500 / \$130 \$5,000 / \$260	
Individual Out-	-of-pocket maximum	,	\$7,000 \$14,000	
HSA plan: Self-	pocket maximum -only coverage deductible		N/A	
HSA family pla	n: Individual deductible		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	njury, illness, or condition	\$35	
Health care provider's office or clinic visit	Other practitioner office visit		\$35	
	Specialist visit		\$75	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imagin		\$75	
	Imaging (CT/PET scans, MRIs	)	\$300	Pharmac
	Tier 1		\$15	deductible
Drugs to treat illness or	Tier 2		\$55	Pharmacy deductible
condition	Tier 3	\$80 20% up to \$250 per	Pharmacy deductible	
	Tier 4 Surgery facility fee (e.g., ASC	)	script after pharmacy deductible 20%	Pharmacy deductible
Outpatient services	Physician/surgeon fees	)	20%	
	Outpatient visit	. 17 1 % 0	20%	
	Emergency room facility fee (v	\$350		
Need	Emergency room physician fe	· ,	No charge	
immediate attention	Emergency medical transporta	ation	\$250	X
	Urgent care		\$35	
Hospital stay	Facility fee (e.g. hospital room	))	20%	Х
	Physician/surgeon fee  Mental/Behavioral health outp	\$35	X	
	Mental/Behavioral health othe	\$35		
	Mental/Behavioral health inpa	000/		
Mental health,	·	20%	X	
behavioral health, or substance	Mental/Behavioral health inpa  Substance Use disorder outpa	20%	X	
abuse needs	Cubstance ese disorder edipe	anom office visits	ψ00	
		outpatient items and services	\$35	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpati		20%	Х
	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	X
	Home health care (cost share	per visit)	\$45	
Help	Outpatient Rehabilitation serv Outpatient Habilitation service		\$35 \$35	
recovering or other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application			
Child Dental	Space Maintainers - Fixed			
Basic	Restorative Procedures		20%	
Services	Periodontal Maintenance Serv		-	

Endodontics

Prosthodontics Oral Surgery

Periodontics (other than maintenance)

Medically necessary orthodontics

50%

50%

Date: Marc							
Summary of	Benefits and Coverage		CCSB Silver		CCSB Silver		
	hare amounts describe the En	rollee's out of pocket costs.	Coinsurance	Plan	Copay Plan		
	e - AV Calculator		71.9%		71.4%		
	cludes a deductible? dividual deductible		Yes, Medical/Ph N/A	armacy	Yes, Medical/Pharmacy N/A		
	amily deductible ductible, NOT integrated: M	odical / Pharmacy / Dental	N/A \$2,000 / \$125	/\$0	N/A \$2,000/ \$125	/ \$0	
Family deduc	ctible, NOT integrated: Medic		\$4,000 / \$250		\$4,000 / \$250		
	-of-pocket maximum pocket maximum		\$7,000 \$14,000		\$7,000 \$14,000		
	- -only coverage deductible nn: Individual deductible		N/A N/A		N/A N/A		
noa railily pla	III. IIIdividual deductible		N/A		IN/A		
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an i	njury, illness, or condition	\$45		\$45		
Health care provider's office or clinic	Other practitioner office visit		\$45		\$45		
visit	Specialist visit		\$75		\$75		
	Preventive care/ screening/ ir	nmunization	No charge		No charge		
Tests	Laboratory Tests  X-rays and Diagnostic Imagin	g	\$40 \$70		\$40 \$70		
	Imaging (CT/PET scans, MRI		20%		\$300		
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmacy deductible	
Drugs to treat	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible	
condition	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	Surgery facility fee (e.g., ASC	)	20%		20%		
services	Physician/surgeon fees Outpatient visit		20%		20% 20%		
	Emergency room facility fee (	vaived if admitted)	\$350		\$350		
		· · · · · · · · · · · · · · · · · · ·					
Need	Emergency room physician fe Emergency medical transport	<u>'</u>	No charge \$250	X	No charge \$250	Х	
ittention	Emergency medical transport	auon	ψ200		<b>\$250</b>		
	Urgent care		\$45		\$45		
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	X	20%	Х	
	Physician/surgeon fee		20%	X	20%	X	
	Mental/Behavioral health outpatient office visits		\$45		\$45		
	Mental/Behavioral health othe	\$45		\$45			
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	20%	Х	
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х	20%	Х	
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$45		\$45		
	Substance Use disorder othe	r outpatient items and services	\$45		\$45		
	Substance Use inpatient facil	ty fee (e.g. hospital room)	20%	Х	20%	Х	
	Substance use disorder inpat	ient physician fee	20%	Х	20%	Х	
	Prenatal care and preconcep		No charge		No charge		
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	20%	х	
	services	Professional	20%	X	20%	Х	
	Home health care (cost share Outpatient Rehabilitation serv	. ,	20% \$45		\$45 \$45		
Help recovering or	Outpatient Habilitation service		\$45		\$45		
other special	Skilled nursing care		20%	х	20%	Х	
health needs	Durable medical equipment Hospice service		20%		20%		
	Eye exam		No charge No charge		No charge No charge		
Child eye care	i pair or glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge		
Child Dental	Oral Exam						
Diagnostic	tic Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge		
and Preventive			, and the second		j		
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures		20%		See 2018 Dental Copay Schedule		
Services	Periodontal Maintenance Ser Crowns and Casts	vices			Jonegule		
Child Dental	Endodontics						
Major Services	Periodontics (other than main	tenance)	50%		See 2018 Dental Copay Schedule		
Child	Oral Surgery  Medically necessary orthodor	itics	50%		\$1,000		
Orthodontics	iviouically flecessary orthodor	iuos	50%		φ1,000		

-	Benefits and Coverage hare amounts describe the Enr	rollee's out of pocket costs	CCSE Silver	
	- AV Calculator	Silos o dat oi pochet costs.	HDHP P	
	cludes a deductible?		Yes, integr	
	dividual deductible mily deductible		\$2,000 integ \$4,000 integ	grated
Individual de	ductible, NOT integrated: Me		N/A	jruiou
Individual Out-	ctible, NOT integrated: Medic -of-pocket maximum	ai / Pharmacy / Dentai	N/A \$6,550	
	pocket maximum -only coverage deductible		\$13,10 \$2,000	
HSA family pla	n: Individual deductible		<del>\$2,600</del> <u>\$2</u>	<u>700</u>
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	20%	Х
Health care provider's office or clinic	Other practitioner office visit		20%	х
visit	Specialist visit		20%	х
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge 20%	X
Tests	X-rays and Diagnostic Imaging		20%	Х
	Imaging (CT/PET scans, MRIs	8)	20%	Х
	Tier 1		20% up to \$250 per script	Х
Drugs to treat illness or	Tier 2		20% up to \$250 per script	Х
condition	Tier 3		20% up to \$250 per script	х
	Tier 4		20% up to \$250 per script	х
Outpatient services	Surgery facility fee (e.g., ASC) Physician/surgeon fees	)	20%	X
services	Outpatient visit		20%	X
	Emergency room facility fee (v	vaived if admitted)	20%	Х
Need	Emergency room physician fe		0%	Х
immediate attention	Emergency medical transportation		20%	Х
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room	))	20%	Х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits		20%	Х
	Mental/Behavioral health othe	r outpatient items and services	20%	х
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	20%	Х
	Substance Use disorder other	outpatient items and services	20%	X
		•		
	Substance Use inpatient facilii Substance use disorder inpati		20%	X
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services  Home health care (cost share	Professional	20% 20%	X
Help	Outpatient Rehabilitation servi	ices	20%	Х
recovering or	Outpatient Habilitation service	S	20%	X
other special health needs	Skilled nursing care		20%	X
	Durable medical equipment Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or of Oral Exam	contact lenses in lieu of glasses)	No charge	
Child Dental	Dental Preventive - Cleaning			
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge	
Child Dental	Space Maintainers - Fixed  Restorative Procedures		000/	
Basic Services	Periodontal Maintenance Serv	rices	20%	
	Crowns and Casts	<u> </u>		
Child Dental Major	Endodontics Periodontics (other than maint	tenance)	50%	
Services	Prosthodontics		30 //	
	Oral Surgery			
Child				

Member Cost S	Benefits and Coverage hare amounts describe the En	rollee's out of pocket costs.	Silver F 100%-150 93.99	% FPL	Silver Plan 150%-200% F 88.0%	
	e - AV Calculator					rma a v
	dividual deductible		Yes, Medical/l		Yes, Medical/Pha	ппасу
	mily deductible ductible, NOT integrated: Mo	odical / Pharmacy / Dontal	N/A \$75 / \$0		N/A \$650 / \$50 / \$	·n
	ctible, NOT integrated: Medic		\$150 / \$0		\$1,300 / \$100 /	
	-of-pocket maximum		\$1,00		\$2,450	
	pocket maximum -only coverage deductible		\$2,00 N/A		\$4,900 N/A	
	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i		\$5		\$10	
Health care provider's office or clinic	Other practitioner office visit		\$5		\$10	
visit	Specialist visit		\$8		\$25	
	Preventive care/ screening/ ir	nmunization	No charge		No charge	
	Laboratory Tests		\$8		\$15	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI		\$8 \$50		\$25 \$100	
		5)				
	Tier 1		\$3		<b>\$</b> 5	Disamosan
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
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	)	10%		15% 15%	
services	Outpatient visit		10%		15%	
	Emergency room facility fee (	waived if admitted)	\$50		\$100	
	Emarganey room physician fo	a (waiwad if admitted)	No oborgo		No charge	
Need	Emergency room physician fe Emergency medical transport	No charge \$30	X	\$75	X	
immediate attention	Emergency medical transport	auon	φ30	^	φ13	^
	Urgent care		\$5		\$10	
Hospital stay	Facility fee (e.g. hospital room	n)	10%	Х	15%	Х
	Physician/surgeon fee		10%	X	15%	Х
	Mental/Behavioral health outpatient office visits		\$5		\$10	
	Mental/Behavioral health othe	er outpatient items and services	\$5		\$10	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	10%	х	15%	х
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$5		\$10	
	Substance Use disorder othe	r outpatient items and services	\$5		\$10	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	10%	X	15%	Х
	Substance use disorder inpat	,	10%	Х	15%	Х
	·			^	-	^
Drognens	Prenatal care and preconcept		No charge	v	No charge	v
Pregnancy	Delivery and all inpatient services	Hospital	10%	X	15%	X
	Home health care (cost share	Professional per visit)	10% \$3	X	15% \$15	X
Help	Outpatient Rehabilitation serv	ices	\$5		\$10	
recovering or	Outpatient Habilitation service	es	\$5		\$10	
other special health needs	Skilled nursing care		10%	Х	15%	Х
	Durable medical equipment Hospice service		10% No charge		15% No charge	
Ohild	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	
01:11	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				<b>N</b> /	
and Preventive	Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental	Space Maintainers - Fixed					
Basic Services	Restorative Procedures  Periodontal Maintenance Service	vices	20%		20%	
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than main Prosthodontics Oral Surgery	tenance)	50%		50%	
Child Orthodontics	Medically necessary orthodor	itics	50%		50%	

Member Cost S	hare amounts describe the En	rollee's out of packet casts	Silver Plan	
	- AV Calculator	onee's out of pocket costs.	200%-250% FP 73.9%	L
	cludes a deductible?			
	dividual deductible		Yes, Medical/Pharr	пасу
	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	N/A \$2,200 / \$130 / \$	<b>\$</b> 0
Family deduc	tible, NOT integrated: Medic		\$4,400 / \$260 / \$	
	-of-pocket maximum pocket maximum		\$5,850 \$11,700	
HSA plan: Self	only coverage deductible		N/A	
HSA family pla	n: Individual deductible		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$30	
Health care provider's office or clinic visit	Other practitioner office visit		\$30	
	Specialist visit		\$75	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge	
Tests	X-rays and Diagnostic Imaging	9	\$35 \$75	
	Imaging (CT/PET scans, MRIs	3)	\$300	
	Tier 1		\$15	Pharmac deductible
Drugs to treat	Tier 2		\$50	Pharmac deductible
condition	Tier 3	\$75	Pharmac deductible	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	20% 20%		
services	Outpatient visit	20%		
	Emergency room facility fee (v	vaived if admitted)	\$350	
	Emergency room physician fe	e (waived if admitted)	No charge	
Need immediate	Emergency medical transporta	<u>'</u>	\$250	Х
attention	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital room	20%	Х	
,	Physician/surgeon fee	20%	Х	
	Mental/Behavioral health outp	\$30		
	Mental/Behavioral health othe	\$30		
	Mental/Behavioral health inpa	20%	Х	
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpa	\$30		
	Substance Use disorder other	outpatient items and services	\$30	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpati	ent physician fee	20%	Х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20% 20%	X X
	Home health care (cost share	per visit)	\$40	
Help recovering or other special	Outpatient Rehabilitation serv Outpatient Habilitation service	\$30 \$30		
	Skilled nursing care	20%	Х	
health needs	Durable medical equipment		20%	. `
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
2,2 02.0	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - Cleaning Preventive - X-ray Seclents per Teeth		No charge	
Child Dental Diagnostic and Preventive			No charge	

20%

50%

50%

Child Dental Basic Services

Restorative Procedures

Prosthodontics Oral Surgery

Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)

Medically necessary orthodontics

Cummary or Denem	s and ooverage				
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Pla	Bronze Plan		e lan
Actuarial Value - AV Ca	Actuarial Value - AV Calculator			61.4%	b
Plan design includes a	deductible?	Yes, Medical/Ph	armacv	Yes, integ	rated
Integrated Individual	leductible	N/A	,	\$4,800 inte	
Integrated Family deductible		N/A		\$9,600 inte	grated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,300 / \$500 / \$0		N/A	
Family deductible, NC	Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,600 / \$1,000 / \$0		
Individual Out-of-pock	et maximum	\$7,000		\$6,550	
Family Out-of-pocket m		\$14,000		\$13,100	
HSA plan: Self-only cov		N/A		\$4,800	
HSA family plan: Individ	lual deductible	N/A		\$4,800	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
			After 1st three		

	of-pocket maximum	\$7,000		\$6,55	
	pocket maximum -only coverage deductible	\$14,000 N/A		\$13,10 \$4,80	
	in: Individual deductible	N/A N/A		\$4,80	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	х
Health care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	х
visit	Specialist visit	\$105	After 1st three non-preventive visits	40%	х
	Preventive care/ screening/ immunization	No charge		No charge	
T4-	Laboratory Tests	\$40		40%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	100%	X	40% 40%	X
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
condition	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	100%	X	40% 40%	X
services	Outpatient visit	100%	X	40%	X
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х
				0%	Х
Need	Emergency room physician fee (waived if admitted)	No charge			
immediate attention	Emergency medical transportation  Urgent care	100% \$75	After 1st three non-preventive visits	40%	X
	Facility fee (e.g. hospital room)	100%	Х	40%	Х
Hospital stay	Physician/surgeon fee	100%	Х	40%	Х
	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health other outpatient items and services	\$75	х	40%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	100%	Х	40%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	Х
	Substance Use disorder other outpatient items and services	\$75	х	40%	х
	Substance Use inpatient facility fee (e.g. hospital room)	100%	Х	40%	х
	Substance use disorder inpatient physician fee	100%	Х	40%	Х
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	100%	Х	40%	Х
	services Professional	100%	X	40%	X
	Home health care (cost share per visit) Outpatient Rehabilitation services	100% \$75	Х	40% 40%	X
Help recovering or	Outpatient Habilitation services	\$75		40%	X
other special	Skilled nursing care	100%	х	40%	х
health needs	Durable medical equipment	100%	Х	40%	Х
	Hospice service	No charge		0%	Х
Child eye care	Eye exam	No charge		No charge	
	i pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning			1	
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application			٠	
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts Endodontics	_		_	
	Periodontics (other than maintenance)	50%		50%	
Child Dental Major		30 /0		JU /0	
Child Dental Major Services	Prosthodontics Oral Surgery				
Major	Prosthodontics	50%		50%	

Summary	οf	Benefits	and	Coverage

Plan design in Integrated In Integrated Fa Individual de Family deduc Individual Out- Family Out-of-	e - AV Calculator cludes a deductible? dividual deductible imily deductible		\$7,350 ir	egrated
Integrated In- Integrated Fa Individual de Family deduc Individual Out- Family Out-of-	dividual deductible imily deductible		\$7,350 ir	
Integrated Fa Individual de Family deduc ndividual Out- Family Out-of-	mily deductible			ntegrated
Individual de Family deduc ndividual Out- Family Out-of-			# # # # # # # # # # # # # # # # # # #	
ndividual Out- amily Out-of-	auctible, NOT integrated: Me	dical / Pharmacy / Dental	\$14,700 l	ntegrated /A
amily Out-of-	ctible, NOT integrated: Medica			/A
	-of-pocket maximum pocket maximum		\$7,3 \$14	,700
	only coverage deductible		N/	/A
HSA family pla	n: Individual deductible		N	/A
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	0%	After 1st three non-preventive visits
Health care provider's office or clinic	Other practitioner office visit		0%	After 1st three non-preventive visits
visit	Specialist visit		0%	Х
	Preventive care/ screening/ im	munization	No charge	
	Laboratory Tests		0%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		0% 0%	X
	Tier 1		0%	Х
Drugs to treat	Tier 2		0%	Х
illness or condition	Tier 3		0%	х
	Tier 4		0%	х
Outpatient	Surgery facility fee (e.g., ASC)		0%	X
outpatient services	Physician/surgeon fees		0%	X
	Outpatient visit	1 17 1 W D	0%	X
	Emergency room facility fee (w	raived it admitted)	0%	Х
Need	Emergency room physician fee	No charge		
mmediate	Emergency medical transportation		0%	Х
attention	Urgent care		0%	After 1st three non-preventiv visits
	Facility fee (e.g. hospital room)		0%	Х
Hospital stay			0%	X
	Physician/surgeon fee		0%	After 1st three
	Mental/Behavioral health outpatient office visits		0%	non-preventiv
	Mental/Behavioral health other	0%	х	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	0%	х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	0%	Х
health, or substance abuse needs	Substance Use disorder outpa		0%	After 1st three non-preventiv visits
	Substance Use disorder other	outpatient items and services	0%	х
	Substance Use inpatient facilit	y fee (e.g. hospital room)	0%	Х
	· ·	, , , ,		
	Substance use disorder inpatie		0%	Х
Dunger	Prenatal care and preconception		No charge	.,
Pregnancy	Delivery and all inpatient services	Hospital	0%	X
	Home health care (cost share	Professional per visit)	0%	X
Help	Outpatient Rehabilitation servi	ces	0%	Х
recovering or	Outpatient Habilitation services	3	0%	X
other special health needs	Skilled nursing care		0%	X
	Durable medical equipment Hospice service		0% 0%	X
01.11.4	Eye exam		No charge	<u> </u>
Child eye care	1 pair of glasses per year (or co	ontact lenses in lieu of glasses)	0%	Х
	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and	Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed		1	
Child Dental				
Basic	Restorative Procedures		0%	Х
Services	Periodontal Maintenance Servi	ices		X
	Crowns and Casts Endodontics		1	X
Objid D		`	00/	
	Periodontics (other than mainte	enance)	0%	
Child Dental Major Services	Periodontics (other than mainted Prosthodontics	enance)	- 0%	X
Major	Periodontics (other than mainted Prosthodontics Oral Surgery	enance)	0%	

# 2018 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: March 14, 2017



Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  10%  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient services  Professional  Hospital  10%  No charge  Professional  10%  No charge  Professional  10%  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation services  \$15  \$15  \$15  \$15  \$15  \$15  \$15  \$1	Summary of	Benefits and Coverage					
Account Name - A Calcidation - 19 1 750	Member Cost S	hare amounts describe the Enrollee's out of pocket costs.					
integrated Family desidentified.  Family desi	Actuarial Value	Actuarial Value - AV Calculator					
Description   Process							
Individual doub-of-potent maximum   \$3.350   \$3.350   \$3.500   \$	Individual de	ductible, NOT integrated: Medical / Pharmacy / Dental		\$0	\$0 / \$0 /		
Family During Section of Section 1999  Permany care what to test and right, lineas, or condition  Modified Exect  Permany care what to test and right, lineas, or condition  Modified Exect  Permany care what to test and right, lineas, or condition  Specialists viait  The 1							
Common   C	Family Out-of-	pocket maximum	\$6,70		\$6,70		
Primary care wild to best an injury, linese, or condition   \$15							
Primary care wild to best an injury, linese, or condition   \$15	7.						
Personal curse  Meastin care  Other practicioner office visit  Specialist visit  Tests  Xiving and Diagnosist impairing immunization  No charge  Tests  Test Specialist visit  Test 1  Test 2  Specialist visit  Test 2  Specialist visit  Test 2  Specialist visit  Test 3  Specialist visit  Test 3  Specialist visit  Test 3  Specialist visit  Test 4  Specialist visit  Test 5  Specialist visit  Test 4  Specialist visit  Test 4  Specialist visit  Test 4  Specialist visit  Test 4  Specialist visit  Test 5  Specialist visit  Test 4  Specialist visit  Test 5  Specialist visit							
Comparison   Com	Medical Event	Service Type	Share	Applies	Share	Applies	
providers or climits  Specialist visit  Feets  Arrays and Dispositio Imaging  Tests  Arrays and Dispositio Imaging  The 1  The 1  Specialist visit  The 2  The 2  Specialist visit  The 3  Specialist visit  The 3  Specialist visit  The 4  Specialist visit  The 3  Specialist visit  The 4  Specialist visit  The 3  Specialist visit  The 4  Specialist visit  The 4  Specialist visit  The 5  Specialist visit  The 6  Specialist visit  The 7  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specia		Primary care visit to treat an injury, illness, or condition	\$15		\$15		
providers or climits  Specialist visit  Feets  Arrays and Dispositio Imaging  Tests  Arrays and Dispositio Imaging  The 1  The 1  Specialist visit  The 2  The 2  Specialist visit  The 3  Specialist visit  The 3  Specialist visit  The 4  Specialist visit  The 3  Specialist visit  The 4  Specialist visit  The 3  Specialist visit  The 4  Specialist visit  The 4  Specialist visit  The 5  Specialist visit  The 6  Specialist visit  The 7  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specialist visit  The 9  Specialist visit  Specialist visit  The 9  Specia							
specialist visit  Specialist visit  Specialist visit  Specialist visit  Proventine caref creening/immunization  Proventine caref creening/immunization  No charge  Description for the company of the charge of the		Other practitioner office visit	\$15		\$15		
Specialist visit   Preventive care screening immunization   No charge   No charge   No charge   No charge   S15	office or clinic		*		***		
Preventive carel screening immunization No charge 155 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15	visit	Specialist visit	\$30		\$30		
Laboratory Tests   Laboratory		Specialist visit	φου		φου		
Test							
Ter 1	Tests						
True 2  True 2  True 3  True 4  True 4  True 4  True 4  True 4  True 5  True 4  True 5  True 4  True 6  True 6  True 6  True 6  True 7  True 7  True 7  True 7  True 7  True 8  True 8  True 8  True 9		Imaging (CT/PET scans, MRIs)	10%		\$75		
Tier 3 Ter 3 Ter 3 Ter 4 Ter 4 Ter 4 Ter 4 Ter 4 Ter 4 Ter 5 Sugery facility fee (e.g., ASC) per script per script services Outpatient Services Outpatient valt Services Substance Services Substance (walved if admitted) Services Servi		Tier 1	\$5		\$5		
Tier 3 Ter 3 Ter 3 Ter 4 Ter 4 Ter 4 Ter 4 Ter 4 Ter 4 Ter 5 Sugery facility fee (e.g., ASC) per script per script services Outpatient Services Outpatient valt Services Substance Services Substance (walved if admitted) Services Servi							
Titer 3 Titer 3 Titer 4 Titer 3 Titer 4 Titer 3 Titer 4 Titer 4 Titer 3 Titer 4 Titer 4 Titer 4 Titer 5 Titer 4 Titer 5 Titer 4 Titer 5 Titer 5 Titer 6 Titer 6 Titer 6 Titer 6 Titer 7 Titer	Drugs to treat	Tier 2	\$15		\$15		
Tier 4 10% up to \$250 per script	illness or						
Description	condition	Tier 3	\$25		\$25		
Description			400/ 1 227		400/		
Supery facility fee (e.g., ASC)   10%   225   Comparison transportation   10%   225   Comparison training transportation   10%   10%   10%   Emergency room facility fee (evalved if admitted)   No charge   No charge   Emergency medical transportation   1550   3150   Emergency medical transportation   1550   3150   Urgent care   515   515    Hospital stay   Facility fee (e.g., hospital room)   10%   10%   10%   International transportation   10%   10%   10%   10%   International transportation   10%   10%   10%   10%   International transportation   10%   10%   10%   10%   10%   International transportation   10%   10%   10%   10%   10%   International transportation   10%   10		Tier 4					
Projection Services   Projection Services   Projection Services   Projection Services   Projection Services   Projection Services   Programs   Projection Services   Programs   Programs   Projection Services   Programs   Projection Services	Outmeticut	Surgery facility fee (e.g., ASC)	10%		\$100		
Emergency room facility fee (walved if admitted)  Emergency room physician fee (walved if admitted)  Emergency room physician fee (walved if admitted)  Emergency room physician fee (walved if admitted)  Urgent care  S150  S150  S150  S150  Hospital stay  Physicianisurgeon fee  Mental/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Mental/Behavioral health other outpatient items and services  Mental/Behavioral health induspatient office visits  Mental/Behavioral health induspatient office visits  Mental/Behavioral health induspatient office visits  S250 per day up to 5 days  Mental/Behavioral health induspatient office visits  S250 per day up to 5 days  Mental/Behavioral health induspatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use inpatient physician fee  Programcy		7					
Emergency room physician fee (waived if admitted)   No charge   No charge							
Immediate attention   Urgent care		Emergency room racinty fee (warved if admitted)	\$150		\$150		
Hospital stay Physician/surgeon fee  Mental/Behavioral health outpatient office visits  Mental/Behavioral health outpatient office visits  Mental/Behavioral health outpatient forfice visits  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Montal health, behavioral health inpatient facility fee (e.g. hospital room)  Montal health, behavioral health inpatient facility fee (e.g. hospital room)  Montal/Behavioral health inpatient facility fee (e.g. hospital room)  Montal/Behavioral health inpatient facility fee (e.g. hospital room)  Substance Use disorder outpatient office visits  Substance Use disorder outpatient facility fee (e.g. hospital room)  Substance Use disorder inpatient facility fee (e.g. hospital room)  Substance Use disorder inpatient facility fee (e.g. hospital room)  Substance Use disorder inpatient facility fee (e.g. hospital room)  Substance Use disorder inpatient physician fee  Prenatal care and preconception visits  No charge  No charge  Home health care (cost sharer per visit)  Outpatient Rehabilitation services  \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$1	Need						
Urgent care		Emergency medical transportation	\$150		\$150		
Hospital stay Pacility fee (e.g. hospital room) 10% 2550 per day up to 5 days 10% No charge 10% No c	attention	Urgent care	¢15		¢15		
Mental/Behavioral health outpatient office visits   \$15   \$15		Orgent care	φισ		\$15		
Mental/Behavioral health outpatient office visits   \$15   \$15		- 112 C ( ) 2 D	100/		\$250 per day up		
Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  Substance Use disorder outpatient office visits  Substance Use disorder outpatient filems and services  Substance Use disorder inpatient physician fee  Moutpatient physician fee  Pregnancy  Pregnan	Hospital stay				to 5 days		
Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  10% No charge  No charge  Substance Use disorder outpatient office visits  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  10% No charge  Pregnancy  Pregn		Physician/surgeon fee	10%		No charge		
Mental health, behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  10% No charge  No charge  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use disorder inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation services  Sti5  Sti5  Sti6  Outpatient Habilitation services  Sti5  Sti6  Sti6  Outpatient Habilitation services  Sti5  Sti6  Outpatient Habilitation services  No charge  No charg		Mental/Behavioral health outpatient office visits	\$15		\$15		
Mental health, behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  10% No charge  No charge  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use disorder inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation services  Sti5  Sti5  Sti6  Outpatient Habilitation services  Sti5  Sti6  Sti6  Outpatient Habilitation services  Sti5  Sti6  Outpatient Habilitation services  No charge  No charg							
Mental health, behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician fee  10% No charge  No charge  Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use disorder inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation services  Sti5  Sti5  Sti6  Outpatient Habilitation services  Sti5  Sti6  Sti6  Outpatient Habilitation services  Sti5  Sti6  Outpatient Habilitation services  No charge  No charg		Mental/Rehavioral health other outpatient items and services	\$15		¢15		
Mental health, behavioral health inpatient racing fee (e.g. inspiral notif)   10%   No charge		Menta/Denavioral nealth other outpatient items and services	φισ		\$15		
Mental Mental/Behavioral health inpatient physician fee 10% No charge behavioral health, or substance use disorder outpatient office visits \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15		Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%				
health, or substance abuse needs  Substance Use disorder other outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient physician fee  10%  No charge  Prenatal care and preconception visits  No charge  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Proflessional  Hospital  Services  Proflessional  10%  No charge  Proflessional  10%  No charge  No charge  Proceeding the health care (cost share per visit)  10%  Substance Use disorder inpatient physician fee  10%  No charge  Pregnancy  Pregnancy  Pregnancy  Proflessional  10%  No charge  Substance Use disorder outpatient physician fee  10%  No charge  No charge  Substance Use disorder outpatient physician fee  10%  No charge  Pregnancy  Pregnancy  Proflessional  10%  No charge  Substance Use disorder outpatient physician fee  10%  No charge  Substance Use disorder outpatient physician fee  10%  No charge  Substance Use disorder outpatient physician fee  10%  No charge  Substance Use disorder outpatient physician fee  10%  No charge  Preventive - X-ray  Saed and seal part Tooth  Preventive - X-ray  Saed and Saes Tooth  Preventive - X-ray  Saed Maintainers - Fixed  Child Dental  Basic  Sarvices  Proflodontics  Not Covered		Mental/Rehavioral health innatient physician fee	10%				
Substance Use disorder outpatient office visits  Substance Use disorder other outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient hospital  Hospital  Home health care (cost share per visit)  Outpatient Rehabilitation services  Substance use disorder inpatient physician fee  Hospital  Hospital  Hospital  Hospital  Howe health care (cost share per visit)  Outpatient Rehabilitation services  Substance Use inpatient physician fee  Hospital  Hospital  Hospital  Hospital  No charge  Noutpatient Habilitation services  Substance Use inpatient physician fee  Hospital  Hospital  No charge  Dupatient Habilitation services  Substance Use disorder inpatient physician fee  Hospital  No charge  No charge  No charge  No charge  No charge  No charge  I pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Preventive - Cleaning  Not Covered	behavioral health, or	Mental/Denavioral nealth inpatient physician ree	1076		No charge		
Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Delivery and all inpatient hospital services  Professional  Hospital  Outpatient Rehabilitation services  Stif  Skilled nursing care  Child over care  Child Dental  Diagnostic  And  Restorative Preventive - Cleaning  Preventive - Services  Preventive - Topical Fluciored Application Space Maintainers - Fixed  Child Dental  Basic  Child Dental  Restorative Procedures  Prosthodontics  Not Covered	substance	Substance Use disorder outpatient office visits	\$15		\$15		
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Professional  Hospital  Home health care (cost share per visit)  Outpatient Rehabilitation services  Stiff  Touther special health needs  Durable medical equipment  Hospice service  No charge  Durable medical equipment  Hospice service  No charge  No charge  No charge  No charge  Town of days  No charge  No ch	abuse needs		*				
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician fee  Prenatal care and preconception visits  Delivery and all inpatient services  Professional  Hospital  Home health care (cost share per visit)  Outpatient Rehabilitation services  Stiff  Touther special health needs  Durable medical equipment  Hospice service  No charge  Durable medical equipment  Hospice service  No charge  No charge  No charge  No charge  Town of days  No charge  No ch							
Substance Use inpatient facility fee (e.g. nospital room)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Pregnancy  Delivery and all inpatient services  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  State outpatient Habilitation services  Outpatient Habilitation services  State outpatient Habilitation services  No charge  No		Substance Use disorder other outpatient items and services	\$15		\$15		
Substance Use inpatient facility fee (e.g. nospital room)  Substance use disorder inpatient physician fee  Pregnancy  Pregnancy  Pregnancy  Delivery and all inpatient services  Home health care (cost share per visit)  Outpatient Rehabilitation services  Outpatient Habilitation services  State outpatient Habilitation services  Outpatient Habilitation services  State outpatient Habilitation services  No charge  No			100/		\$250 per day up		
Pregnancy Delivery and all inpatient services Delivery and all inpatient services Professional Home health care (cost share per visit) Hospital Duptatient Rehabilitation services Stiff of the special health needs Durable medical equipment Hospice service Durable medical equipment Hospice service Thild pental Diagnostic and Preventive - Cleaning Preventive - Cleaning Preventive - Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Prosthodontics Oral Surgery Professional 10% No charge 10% S20 No charge 10% S215 S15 S15 S15 S15 S15 S15 S15 S15 S15 S		oubstance Use inpatient facility fee (e.g. hospital room)	10%				
Pregnancy Delivery and all inpatient services Professional Professional Dupatient Rehabilitation services Skilled nursing care Durable medical equipment Hospital eye exam Child Dental Diagnostic and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Prosthodontics Child Dental Preventice Child Dental Preventice Preventice Prosthodontics Child Dental Preventice Prosthodontics Oral Surgery Prosthodontics Oral Surgery Prosthodontics Oral Surgery Prosthodontics Oral Surgery Prostored Prost Covered Prost Covered Prost Covered Not Covered		Substance use disorder inpatient physician fee	10%		No charge	L	
Home health care (cost share per visit)   10%   10%   No charge		Prenatal care and preconception visits	No charge				
Home health care (cost share per visit)  Help Outpatient Rehabilitation services  Outpatient Habilitation services  Outpatient Habilitation services  Statistic  Outpatient Habilitation services  Outpatient Habilitation services  Statistic  Statistic  Outpatient Habilitation services  Statistic  S	Pregnancy						
Help recovering or other special health needs  Outpatient Habilitation services  Stiled nursing care  No charge  Durable medical equipment Hospice service  No charge  Thild eye care  Oral Exam  Child Dental  Diagnostic and Sealants per Tooth Preventive - Cleaning Preventive - X-ray Space Maintainers - Fixed  Child Dental Basic  Periodontal Maintenance Services  Crowns and Casts Endodontics Prosthodontics Oral Surgery  Not Covered  Not Covered  Not Covered		Professional					
other special health needs  Skilled nursing care  Skilled nursing care  Durable medical equipment Hospice service  No charge  Thild eye care  Child Dental Diagnostic and Space Maintainers - Fixed  Child Dental Basic  Child Den	Help	Outpatient Rehabilitation services	\$15		\$15		
Durable medical equipment   10%	recovering or						
Durable medical equipment 10% 10% 10% 10% 10% 10% 10% 10% 10% 10%	other special health needs				to 5 days		
Eye exam							
Oral Exam Child Dental Diagnostic and Sealants per Tooth Preventive - Cleaning Preventive - A-ray Sealants per Tooth Preventive - Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Child Dental Major Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered	Child area						
Child Dental Diagnostic Preventive - Cleaning Diagnostic Preventive - X-ray Not Covered Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Not Covered Services Periodontal Maintenance Services  Child Dental Basic Covered Periodontal Maintenance Services Periodontics (other than maintenance) Not Covered Not	onnu eye care		No charge		No charge		
Diagnostic and Sealants per Tooth Sealants per Tooth Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Sealants Per Tooth Services Periodontal Maintenance Services Crowns and Casts Endodontics Services Periodontics (other than maintenance) Not Covered Not Co	Child Dental						
and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Periodontics (other than maintenance) Prosthodontics Oral Surgery  Child Medically necessary orthodontics Not Covered	Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
Space Maintainers - Fixed  Child Dental Basic  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery  Child  Medically necessary orthodontics  Not Covered			55.0104		00.0104		
Restorative Procedures							
Periodontal Maintenance Services		Restorative Procedures	Not Covered		Not Covered		
Child Dental Major   Periodontics (other than maintenance)   Not Covered   Not Covered							
Major   Periodontics (other than maintenance)   Not Covered   Not Covered							
Services Prosthodontics Not Covered Oral Surgery Not Covered Not C			Not Covered				
Child Medically necessary orthodontics Not Covered Not Covered		` ,	1				
Medically necessary orthodontics Not Covered Not Covered		Oral Surgery			Not Covered		
		Medically necessary orthodontics	Not Covered		Not Covered		

# 2018 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: March 14, 2017

Summary of	Benefits and Coverage					
	hare amounts describe the En	rollee's out of pocket costs.	Coinsurance	e Plan	Gold Copay P	lan
	e - AV Calculator cludes a deductible?		81.89 No	0	78.4% No	)
Integrated In	dividual deductible		\$0		\$0	
Individual de	ductible, NOT integrated: Me	\$0 \$0 / \$0		\$0 \$0 / \$0 /		
	ctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$0 / \$0 / \$6,00		\$0 / \$0 / \$6,000	
	pocket maximum -only coverage deductible		\$12,00 N/A	00	\$12,00 N/A	0
	n: Individual deductible		N/A		N/A	
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event	Se	rvice Type	Share	Applies	Share	Applies
	Primary care visit to treat an in	njury, illness, or condition	\$25		\$25	
Health care						
provider's office or clinic	Other practitioner office visit		\$25		\$25	
visit						
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$55		\$35 \$55	
	Imaging (CT/PET scans, MRIs	3)	20%		\$275	
	Tier 1		\$15		\$15	
	Tier 2		\$55		\$55	
Drugs to treat illness or	-:- <u>-</u>		ΨΟΟ		φυυ	
condition	Tier 3		\$75		\$75	
	/	20% up to \$250		20% up to \$250		
	Tier 4		per script		per script	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees		20%		\$300 \$40	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (v	vaived if admitted)	\$325		\$325	
Need	Emergency room physician fe	No charge		No charge		
immediate attention	Emergency medical transporta	ation	\$250		\$250	
	Urgent care		\$25		\$25	
Hospital stay	Facility fee (e.g. hospital room	)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health outp	\$25		\$25		
	Mental/Behavioral health othe	\$25		\$25		
	Mantal/Pahayiaral haalth inna	200/		\$600 per day up		
Mental health,	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%		to 5 days	
behavioral health, or	мента/веначога неанн пра	tient physician lee	20%		No charge	
substance abuse needs	Substance Use disorder outpa	\$25		\$25		
	Substance Use disorder other	outpatient items and services	\$25		\$25	
					\$600 per day up	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%		to 5 days	
	Substance use disorder inpati		20%		No charge	
D	Prenatal care and preconcept		No charge		No charge \$600 per day up	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%		to 5 days  No charge	
	Home health care (cost share	per visit)	20%		\$30	
Help recovering or	Outpatient Rehabilitation serv Outpatient Habilitation service		\$25 \$25		\$25 \$25	
other special	Skilled nursing care		20%		\$300 per day up to 5 days	
health needs	Durable medical equipment Hospice service		20% No charge		20% No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Serv	rices	Oovered			
Child Dental	Crowns and Casts Endodontics				Not Covered Not Covered	
Major Services	Periodontics (other than main	renance)	Not Covered		Not Covered	
Jei vices	Prosthodontics Oral Surgery				Not Covered Not Covered	
Child	Medically necessary orthodon	tics	Not Covered		Not Covered	
Orthodontics						

Summary of	Benefits and Coverage		Individual	
Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan	ו
	- AV Calculator		71.9%	
	cludes a deductible? dividual deductible		Yes, Medical/Pha N/A	armacy
Integrated Fa	mily deductible	adical / Dhamasay / Dantal	N/A	/ <b>(</b>
	ductible, NOT integrated: Metible, NOT integrated: Medic		\$2,500/ \$130 \$5,000/ \$260	
	-of-pocket maximum		\$7,000 \$14,000	
HSA plan: Self	only coverage deductible		N/A	
HSA family pla	n: Individual deductible		N/A	
Common Medical Event	Se	ervice Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an i	njury, illness, or condition	\$35	
Health care provider's office or clinic	Other practitioner office visit		\$35	
visit	Specialist visit		\$75	
	Preventive care/ screening/ in	mmunization	No charge	
Гests	Laboratory Tests X-rays and Diagnostic Imagin	g	\$35 \$75	
	Imaging (CT/PET scans, MRI	s)	\$300	
	Tier 1		\$15	Pharmac deductibl
Drugs to treat	Tier 2		\$55	Pharmac deductible
condition	Tier 3		\$80	Pharmac deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	···	20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (	waived if admitted)	\$350	
	Emergency room physician fe	ee (waived if admitted)	No charge	
Need mmediate	Emergency medical transportation		\$250	Х
attention	Urgent care		\$35	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х
	Physician/surgeon fee  Mental/Behavioral health outpatient office visits		\$35	X
	Mental/Behavioral health other outpatient items and services		\$35	
			2001	.,
Wental health,	·	atient facility fee (e.g.hospital room)	20%	Х
pehavioral health, or	Mental/Behavioral health inpa	atient physician fee	20%	Х
substance abuse needs	Substance Use disorder outpatient office visits		\$35	
	Substance Use disorder othe	r outpatient items and services	\$35	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat	ient physician fee	20%	Х
	Prenatal care and preconcep		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	Х
John	Home health care (cost share Outpatient Rehabilitation serv		\$45 \$35	
Help recovering or	Outpatient Habilitation service		\$35	
other special nealth needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% No charge	
Child over and	Eye exam		No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Doctol	Restorative Procedures		Not Covered	
Basic				
Child Dental Basic Services Child Dental	Crowns and Casts Endodontics			
Basic Services Child Dental Major	Crowns and Casts		Not Covered	
Basic Services Child Dental	Crowns and Casts Endodontics		Not Covered	

	:N 14, 2017					
•	Benefits and Coverage		CCSB Silver		CCSB Silver	
	hare amounts describe the En	rollee's out of pocket costs.	Coinsurance Plan		Copay Plan	
	e - AV Calculator cludes a deductible?		71.9%		71.4%	
Integrated Inc	dividual deductible		Yes, Medical/Pharmacy N/A		Yes, Medical/Pharmacy N/A	
Individual de	mily deductible ductible, NOT integrated: M		N/A \$2,000 / \$125		N/A \$2,000/ \$125 / \$0	
Family deduc	ctible, NOT integrated: Medi- -of-pocket maximum		\$4,000 / \$250 \$7,000		\$4,000 / \$250 \$7,000	
Family Out-of-	pocket maximum		\$14,000		\$14,000	
	-only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$45		\$45	
Health care provider's office or clinic	Other practitioner office visit	\$45		\$45		
visit	Specialist visit	\$75		\$75		
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$40		No charge \$40	
Tests	X-rays and Diagnostic Imagin		\$70		\$70	
	Imaging (CT/PET scans, MRI	s)	20%		\$300	
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmacy deductible
Drugs to treat illness or	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$85 20% up to \$250 per	Pharmacy deductible	\$85 20% up to \$250 per	Pharmacy deductible
	Tier 4		script after pharmacy deductible	Pharmacy deductible	script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	)	20%		20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (	waived if admitted)	\$350		\$350	
Nood	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transport	\$250	Х	\$250	Х	
attention	Urgent care		\$45		\$45	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х	20%	Х
	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health outp	\$45		\$45		
	Mental/Behavioral health othe	\$45		\$45		
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х	20%	х
health, or substance abuse needs	Substance Use disorder outp	\$45		\$45		
	Substance Use disorder othe	\$45		\$45		
	Substance Use inpatient facil	20%	X	20%	Х	
	Substance use disorder inpat	,	20%	X	20%	Х
	Prenatal care and preconcep		No charge	^	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	X	20%	х
	services	Professional	20%	X	20%	X
	Home health care (cost share Outpatient Rehabilitation serv	. ,	20% \$45		\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45 \$45		\$45	
other special	Skilled nursing care		20%	х	20%	х
health needs	Durable medical equipment Hospice service		20%		20%	
01.11	Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning				1	
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application					
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Ser	vices				
Child Dental	Crowns and Casts Endodontics				Not Covered Not Covered	
Major	Periodontics (other than main	tenance)	Not Covered		Not Covered	
Services	Prosthodontics Oral Surgery				Not Covered Not Covered	
	o.a. oargory				1401 COVELEG	
Child	Medically necessary orthodor		Not Covered		Not Covered	

-	Benefits and Coverage hare amounts describe the Eni	rallee's aut of nacket casts	CCSB Silver	
	e - AV Calculator		HDHP PI 71.7%	
	cludes a deductible?		Yes, integr	
Integrated In	dividual deductible		\$2,000 integ	grated
	imily deductible ductible, NOT integrated: Me	edical / Pharmacy / Dental	\$4,000 integ N/A	grated
	ctible, NOT integrated: Medic	al / Pharmacy / Dental	N/A \$6,550	<b>\</b>
	pocket maximum		\$13,10	
	only coverage deductible n: Individual deductible		\$2,000 <del>\$2,600</del> \$2,	
TIOA failing pla	iii. Ilidividaal deductible		<del>ψ</del> 2,000 <u>ψ</u> 2,	700
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	njury, illness, or condition	20%	х
Health care provider's office or clinic	Other practitioner office visit		20%	х
/isit	Specialist visit		20%	×
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	n	20% 20%	X
16212	Imaging (CT/PET scans, MRIs		20%	X
	Tier 1		20% up to \$250 per script	x
Drugs to treat	Tier 2		20% up to \$250 per script	x
illness 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%	X
Outpatient services	Physician/surgeon fees	)	20%	X
Services	Outpatient visit		20%	X
	Emergency room facility fee (v	vaived if admitted)	20%	Х
Need	Emergency room physician fe	e (waived if admitted)	0%	x
immediate	Emergency medical transportation		20%	Х
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room	))	20%	Х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits		20%	х
	Mental/Behavioral health othe	r outpatient items and services	20%	х
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	20%	X
abase necas				
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpati		20%	Х
	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care (cost share	Professional per visit)	20%	X
Help	Outpatient Rehabilitation serv	ices	20%	Х
recovering or	Outpatient Habilitation service	es	20%	X
other special health needs	Skilled nursing care		20%	X
	Durable medical equipment Hospice service		20%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning		1	
Diagnostic and	Preventive - X-ray		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application			
Child Dental	Space Maintainers - Fixed			
Basic	Restorative Procedures		Not Covered	
Services	Periodontal Maintenance Serv	vices		
Child Dental	Crowns and Casts Endodontics			
Major	Periodontics (other than main	tenance)	Not Covered	
Services	Prosthodontics			
	Oral Surgery			
Child				

Summary of Benefits and Coverage			Silver Plan		Silver Plan	
	ember Cost Share amounts describe the Enrollee's out of pocket costs.		100%-150% FPL 93.9%		150%-200% FPL 88.0%	
	cludes a deductible?		Yes, Medical/l		Yes, Medical/Pha	rmacy
	dividual deductible		N/A N/A		N/A N/A	•
Individual de	ductible, NOT integrated: Me		\$75 / \$0	/ \$0	\$650 / \$50 / \$ \$1,300 / \$100 /	
Individual Out-	ctible, NOT integrated: Medic -of-pocket maximum	ai / Pharmacy / Dentai	\$150 / \$0 \$1,00	0	\$2,450	<b>\$</b> U
	pocket maximum -only coverage deductible		\$2,00 N/A	0	\$4,900 N/A	
HSA family pla	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	\$5		\$10		
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$10	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$8		No charge \$15	
Tests	X-rays and Diagnostic Imaging		\$8		\$25	
	Imaging (CT/PET scans, MRIs	3)	\$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
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	<u> </u>	10% 10%		15% 15%	
services	Outpatient visit		10%		15%	
	Emergency room facility fee (v	vaived if admitted)	\$50		\$100	
Need	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
immediate	Emergency medical transporta	\$30	X	\$75	Х	
attention	Urgent care		\$5		\$10	
Hospital stay	Facility fee (e.g. hospital room	)	10%	Х	15%	Х
	Physician/surgeon fee		10%	X	15%	X
	Mental/Behavioral health outp	\$5		\$10		
	Mental/Behavioral health othe	\$5		\$10		
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%	Х	15%	х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	10%	х	15%	Х
health, or substance abuse needs	Substance Use disorder outpa	\$5		\$10		
	Substance Use disorder other	\$5		\$10		
	Substance Use inpatient facility fee (e.g. hospital room)		10%	Х	15%	Х
	Substance use disorder inpati	ent physician fee	10%	х	15%	Х
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%	Х	15%	х
	services  Home health care (cost share	Professional	10%	X	15%	X
Help	Outpatient Rehabilitation servi	ces	\$3 \$5		\$15 \$10	
recovering or	Outpatient Habilitation service	S	\$5		\$10	
other special health needs	Skilled nursing care		10%	Х	15%	Х
	Durable medical equipment Hospice service		10% No charge		15% No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or o Oral Exam	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Serv Crowns and Casts	ices				
Child Dental	Endodontics					
Major Services	Periodontics (other than maint Prosthodontics	enance)	Not Covered		Not Covered	
Child	Oral Surgery					
Orthodontics	Medically necessary orthodon	tics	Not Covered		Not Covered	

Member Cost St	hare amounts describe the En	rollee's out of nocket costs	Silver Plan	
		ollee's out of pocket costs.	200%-250% FF 73.9%	L
	e - AV Calculator cludes a deductible?			
	dividual deductible		Yes, Medical/Phari N/A	пасу
	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	N/A \$2,200 / \$130 / \$	\$n
Family deduc	tible, NOT integrated: Medic		\$4,400 / \$260 / \$	
	-of-pocket maximum pocket maximum		\$5,850 \$11,700	
	only coverage deductible n: Individual deductible		N/A N/A	
rioA lailily pla	n. marviduai deductible		IV/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	\$30	
Health care provider's office or clinic visit	Other practitioner office visit		\$30	
	Specialist visit		<b>\$7</b> 5	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imaging		\$75	
	Imaging (CT/PET scans, MRIs	3)	\$300	
	Tier 1		\$15	Pharmacy deductible
Drugs to treat	Tier 2		\$50	Pharmacy deductible
condition	Tier 3	\$75	Pharmacy deductible	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20%	
services	Outpatient visit		20%	
	Emergency room facility fee (v	vaived if admitted)	\$350	
Nasad	Emergency room physician fe	e (waived if admitted)	No charge	
Need immediate	Emergency medical transporta	ation	\$250	Х
attention	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital room	)	20%	Х
	Physician/surgeon fee  Mental/Behavioral health outp	atient office visits	\$30	X
	Mental/Behavioral health othe	r outpatient items and services	\$30	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpa	\$30		
	Substance Use disorder other outpatient items and services		\$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	Х
	Substance use disorder inpati	ent physician fee	20%	Х
	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care (cost share	Professional per visit)	20% \$40	Х
Help	Outpatient Rehabilitation serv	ces	\$30	
recovering or	Outpatient Habilitation service	S	\$30	
other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% No charge	
Child eye care	Eye exam		No charge	
willing eve care	1 pair of glasses per year (or o	No charge		

Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses)

Oral Exam
Preventive - Cleaning
Preventive - X-ray
Sealants per Tooth
Topical Fluoride Application
Space Maintainers - Fixed

Restorative Procedures

Prosthodontics Oral Surgery

Periodontal Maintenance Services
Crowns and Casts
Endodontics

Medically necessary orthodontics

Periodontics (other than maintenance)

Child Dental Diagnostic and Preventive

Child Dental Basic Services

Child Dental Major Services

No charge

Not Covered

Not Covered

Not Covered

Not Covered

•	Benefits and Coverage			Bronz	e	
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	HDHP Plan		
Actuarial Value	e - AV Calculator	60.8%		61.4%	Ď	
	cludes a deductible? dividual deductible	Yes, Medical/Pha N/A	Yes, integrated \$4,800 integrated			
Integrated Family deductible		N/A		\$9,600 inte		
	ductible, NOT integrated: Medical / Pharmacy / Dental ctible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 \$12,600 / \$1,00		N/A N/A		
ndividual Out-	-of-pocket maximum	\$7,000		\$6,550		
	pocket maximum -only coverage deductible	\$14,000 N/A		\$13,10 \$4,800		
	n: Individual deductible	N/A		\$4,800	כ	
Common			Deductible	Member Cost	Deductib	
Medical Event	Service Type	Member Cost Share	Applies	Share	Applies	
	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	х	
Health care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	х	
<i>r</i> isit	Specialist visit	\$105	After 1st three non-preventive visits	40%	х	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$40		No charge 40%	X	
ests	X-rays and Diagnostic Imaging	100%	Х	40%	Х	
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
Orugs to treat Ilness or	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
condition	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	100%	X	40%	X	
services	Outpatient visit	100%	X	40%	Х	
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х	
Need	Emergency room physician fee (waived if admitted)	No charge		0%	Х	
mmediate	Emergency medical transportation	100%	X	40%	Х	
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х	
Hospital stay	Facility fee (e.g. hospital room)	100%	Х	40%	Х	
	Physician/surgeon fee	100%	X	40%	Х	
	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	х	
	Mental/Behavioral health other outpatient items and services	\$75	х	40%	х	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	Х	
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	100%	Х	40%	Х	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	Х	
	Substance Use disorder other outpatient items and services	\$75	х	40%	х	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	Х	40%	х	
	Substance use disorder inpatient physician fee	100%	х	40%	Х	
	Prenatal care and preconception visits	No charge	· ·	No charge		
Pregnancy	Delivery and all inpatient services Hospital	100%	X	40%	X	
	Professional Home health care (cost share per visit)	100% 100%	X	40%	X	
lelp	Outpatient Rehabilitation services Outpatient Habilitation services	\$75 \$75		40% 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	
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge No charge		No charge No charge		
	Oral Exam	. to only b		. 13 Gridige		
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed  Restorative Procedures	Net Covered		Not Covered		
Basic Bervices	Periodontal Maintenance Services Crowns and Casts	Not Covered		Not Covered		
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics	1				

Not Covered

Not Covered

Prosthodontics Oral Surgery

Medically necessary orthodontics

Summary	of B	enefits	and	Coverage
Jan	·	01101110	u	oo to.ugo

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Catastro	ohic Plan
Actuarial Value	e - AV Calculator		
Plan design in	cludes a deductible?	Yes, int	egrated
	dividual deductible	\$7,350 ir	
	amily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	\$14,700 i N	
Family deduc	ctible, NOT integrated: Medical / Pharmacy / Dental	N/	'A
	-of-pocket maximum pocket maximum	\$7,3 \$14,	
	-only coverage deductible	\$14, N	
HSA family pla	n: Individual deductible	N/	Ά
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits
Health care provider's office or clinic	Other practitioner office visit	0%	After 1st three non-preventive visits
isit	Specialist visit	0%	х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%	X
	inaging (OTA ET Sound, Willia)	070	^
	Tier 1	0%	Х
Drugs to treat	Tier 2	0%	Х
condition	Tier 3	0%	х
	Tier 4	0%	Х
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees Outpatient visit	0%	X
	·		
	Emergency room facility fee (waived if admitted)	0%	Х
Mood	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate	Emergency medical transportation	0%	Х
attention	Urgent care	0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)	0%	Х
	Physician/surgeon fee	0%	X
	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services	0%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	0%	Х
nealth, or substance abuse needs	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services	0%	X
	Substance Use inpatient facility fee (e.g. hospital room)	0%	Х
	Substance use disorder inpatient physician fee	0%	Х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient services Hospital	0%	Х
	Professional	0%	X
	Home health care (cost share per visit)  Outpatient Rehabilitation services	0% 0%	X
Help recovering or	Outpatient Habilitation services	0%	X
other special	Skilled nursing care	0%	Х
health needs	Durable medical equipment	0%	Х
	Hospice service	0%	X
Child eye care	Eye exam	No charge	V
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
Child Dental	Oral Exam Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application	0076160	
revendve	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
Child Dental	Crowns and Casts Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics	1	
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

#### **Endnotes to Covered California 2018 Patient-Centered Benefit Plan Designs**

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

#### Notes:

- 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. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$X,XXX2,700 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.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2017 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

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

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

- 24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic

outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.

- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.