## Covered California 2019 2020 Patient-Centered Benefit Plan Designs<sup>1</sup>

## Final Board-approved Proposed March 15, 2018 February 21, 2019

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



ummary of Bei	nefits and Coverage		И			
-	amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance		Platinum Copay Pla		
tuarial Value - A	V Calculator	91.7%		88.9 <u>89.1</u> %		
	Plan design includes a deductible?	No		No		
	Integrated Individual deductible	\$0		\$0		
	Integrated Family deductible	\$0		\$0		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0	
	Individual Out-of-pocket maximum	<del>\$3,350<u>\$4,5</u></del>	<u>00</u>	<del>\$3,350<u>\$4,5</u></del>	<u>00</u>	
	Family Out-of-pocket maximum	<del>\$6,700<u>\$9,0</u></del>	<u>00</u>	\$ <del>6,700<u>\$9,0</u></del>	<u>00</u>	
	HSA plan: Self-only coverage deductible			N/A		
Common	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie	
	Primary care visit to treat an injury, illness, or condition	\$15		\$15		
Health care provider's office or	Other practitioner office visit	\$15		\$15		
clinic visit	Specialist visit	\$30		\$30		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$15		\$15		
Tests	X-rays and Diagnostic Imaging	\$30		\$30		
	Imaging (CT/PET scans, MRIs)	10%		\$75		
	Tier 1	\$5		\$5		
Drugs to	Tier 2	\$15		\$15		
reat illness or condition	Tier 3	\$25		\$25		
	Tier 4	10% up to \$250 per		10% up to \$250 per		
_		script		script		
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100		
ervices	Physician/surgeon fees	10%		\$25		
	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$150		\$150		
Need mmediate	Emergency room physician fee (waived if admitted)	No charge		No charge		
attention	Medical transportation (including emergency and non-emergency)	\$150		\$150		
	Urgent care	\$15		\$15		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		5 days No charge		
Viental	Mental/behavioral health and substance use disorder outpatient office					
nealth, behavioral	visits	\$15		\$15		
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	10%		\$20		
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$15		
ecovering or	Skilled nursing care	10%		\$150 per day up to		
other special nealth needs	-			5 days		
	Durable medical equipment	10%		10%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	No charge		No charge		
and Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	200/		See 20192020		
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule		
	Crowns and Casts					
	Endodontics			0		
Child Dental Najor	Periodontics (other than maintenance)	50%		See 20192020 Dental Copay		
Services	Prosthodontics			Schedule		
	Oral Surgery					
	Ulai Suldelv					

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
uarial Value - AV	✓ Calculator	<del>81.8<u>81.9</u>%</del>		<del>78.1<u>78.3</u>9</del>	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	<del>\$7,200<u>\$7,85</u></del>	<u>50</u>	<del>\$7,200<u></u>\$7,8</del>	<u>50</u>
	Family Out-of-pocket maximum	\$14,400 <u>\$15,7</u>	<u>'00</u>	<del>\$14,400<u>\$15,</u></del>	<u>700</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's office or	Other practitioner office visit	\$30		\$30	
clinic visit	Specialist visit	<del>\$55</del> <u>\$60</u>		<del>\$55</del> <u>\$60</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	<del>\$35<u></u>\$40</del>		<del>\$35<u>\$40</u></del>	
Tests	X-rays and Diagnostic Imaging	<u>\$55<u>\$75</u></u>		<del>\$55</del> <u>\$75</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1				
	Tier 2	\$15		\$15	
Drugs to reat illness	1101 2	\$55		\$55	
or condition	Tier 3	<del>\$75<u>\$80</u></del>		<del>\$75<u>\$80</u></del>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Dutpatient	Physician/surgeon fees	20%		\$40	
ervices	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)				
		\$ <u>325\$350</u>		\$ <u>325\$350</u>	
leed mmediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$30		\$30	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%		\$600 per day up to 5 days	
lospital stay	Physician/surgeon fee	20%		No charge	
lental		2070		i to onalgo	
ealth, ehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$30		\$30	
ealth, or substance subse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30		\$30	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
		\$30		\$30	
lelp ecovering or	Outpatient Rehabilitation and Habilitation services			\$30 \$300 per day up to	
ther special	Skilled nursing care	20%		5 days	
ealth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
hild Dental	Preventive - X-ray				
)iagnostic nd		No charge		No charge	
reventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental Basic	Restorative Procedures	20%		See 20192020 Dental Copay	
ervices	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 20192020	
Major Services	Periodontics (other than maintenance)	50%		Dental Copay Schedule	
				Schedule	
Jei vices	Prosthodontics				
Services	Prosthodontics Oral Surgery				

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	<u>CCSB-only</u> Gold Coinsurance Pla	1	<u>CCSB-only</u> Gold Copay Plan	
tuarial Value - A	V Calculator	Coinsurance Pla 81.878.1%		78.179.7%	
	Plan design includes a deductible?	NoYes, Medical/Pharr	nacy	NeYes, Medical/Pha	rmacy
	Integrated Individual deductible	\$0 <u>N/A</u>		\$0 <u>N/A</u>	<u>indoy</u>
	Integrated Family deductible	\$0 <u>N/A</u>		\$0 <u>N/A</u>	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$0<u>\$250</u> / \$0 / \$0</del>		<del>\$0<u></u>\$250</del> / \$0 / \$(	D
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$0<u>\$500</u> / \$0 / \$0</del>		<del>\$0<u></u>\$500</del> / \$0 / \$(	C
	Individual Out-of-pocket maximum	<del>\$7,200<u>\$7,850</u></del>		<del>\$7,200<u>\$7</u>,850</del>	
	Family Out-of-pocket maximum	\$ <del>14,400<u>\$15,700</u></del>		<del>\$14,400<u>\$15,70</u>0</del>	<u>c</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
-	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
Health care provider's	Other practitioner office visit	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
office or clinic visit	Specialist visit	¢EE¢EO		¢EE¢EO	
chine visit	Specialist visit	<del>\$55</del> <u>\$50</u>		<del>\$55</del> <u>\$50</u>	
_	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	<del>\$35</del> <u>\$25</u>		<del>\$35<u></u>\$25</del>	
<b>Fests</b>	X-rays and Diagnostic Imaging	<del>\$55</del> <u>\$65</u>		<del>\$55</del> <u>\$65</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to reat illness	Tier 2	<del>\$55<u>\$50</u></del>		<del>\$55<u>\$50</u></del>	
or condition	Tier 3	<del>\$75</del> <u>\$80</u>		<del>\$75<u>\$</u>80</del>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	<del>\$325</del> <u>\$250</u>	X	<del>\$325</del> <u>\$250</u>	X
Need	Emergency room physician fee (waived if admitted)	No charge	_	No charge	_
immediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention					
	Urgent care	<del>\$30</del> <u>\$25</u>		<del>\$30<u>\$25</u></del>	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	X
,	Physician/surgeon fee	20%	X	No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	000005		000005	
health, behavioral	visits	<del>\$30</del> <u>\$25</u>		<del>\$30</del> <u>\$25</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	000005		000005	
abuse needs	items and services	<del>\$30<u></u>\$25</del>		<del>\$30<u></u>\$25</del>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	<del>20%<u>\$30</u></del>		\$30	
Help	Outpatient Rehabilitation and Habilitation services	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
recovering or	Skilled nursing care	20%	x	\$300 per day up to 5 days	<u>x</u>
other special health needs	Durable medical equipment	20%		20%	~
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	0.000		See <del>2019</del> 2020 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 20192020 Dental Copay	
Services	, , ,	50 70		Schedule	
	Prosthodontics				
01-11-1	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
tuarial Value - A	V Calculator	<del>71.8<u>71.7</u>%</del>	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 <u>\$4,000</u> / \$200 <u>\$3</u>	00 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 <u>\$4,000</u> / \$200 <u>\$6</u> \$5,000\$8,000 / \$400\$6	
	Individual Out–of–pocket maximum	<del>\$7,550<u>\$7,850</u></del>	
	Family Out-of-pocket maximum	<del>\$15,100</del> <u>\$15,700</u>	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit	\$40	
office or clinic visit	Craciplict visit	¢00	
CIINIC VISIT	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
Teets	Laboratory Tests	\$35 <u>\$40</u>	
Tests	X-rays and Diagnostic Imaging	<del>\$75<u>\$85</u></del>	
	Imaging (CT/PET scans, MRIs)	<del>\$300</del> <u>\$325</u>	Dharm
	Tier 1	<del>\$15<u></u>\$16</del>	Pharma deductil
Drugs to	Tier 2	<del>\$55<u>\$60</u></del>	Pharma deductil
treat illness			Pharma
or condition	Tier 3	<del>\$80<u></u>\$90</del>	deductil
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductil
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$ <u>350</u> \$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate	Medical transportation (including emergency and non-emergency)	\$250	×
attention	Urgent care	\$40	~
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	20%	Х
	Physician/surgeon fee	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$40	
recovering or other special	Skilled nursing care	20%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child ove	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
	-		
		No shares	
Diagnostic	Preventive - X-ray Sealants per Tooth	No charge	
Diagnostic and	Sealants per Tooth	No charge	
Diagnostic and	Sealants per Tooth Topical Fluoride Application	No charge	
Diagnostic and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge	
Diagnostic and Preventive Child Dental Basic	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	No charge	
Diagnostic and Preventive Child Dental Basic	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services		
Diagnostic and Preventive Child Dental Basic	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts		
Diagnostic and Preventive Child Dental Basic Services Child Dental	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	20%	
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)		
Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	20%	

#### 20192020 Patient-Centered Benefit Plan Designs 10.0 EHB 15 2019Eab v 21 2010

Oral Surgery

Medically necessary orthodontics

Child Orthodor

ummary of Ber	nefits and Coverage	CCSB <u>-only</u>		CCSB <u>-only</u>	
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plar		Silver	
ctuarial Value - A	/ Calculator		1	Copay Plan	
cluariar value - Av		<del>71.9<u>70.5</u>%</del>		<del>71.6<u>70.2</u>%</del>	
	Plan design includes a deductible?		асу	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ <del>2,000<u>\$2,250</u> / \$<del>200<u></u>\$30</del></del>	<u>)0</u> / \$0	<del>\$2,000<u></u>\$2,250</del> / <del>\$200<u></u>\$3</del>	<u>800</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$4,000<u>\$4,500</u> / \$400<u>\$60</u></del>	<u>)0</u> / \$0	<del>\$4,000<u>\$4,500</u> / \$400<u>\$6</u></del>	<u>600</u> / \$0
	Individual Out–of–pocket maximum	<del>\$7,550<u>\$7,850</u></del>		<del>\$7,550<u>\$7,850</u></del>	
	Family Out-of-pocket maximum	<del>\$15,100<u>\$15,700</u></del>		<del>\$15,100<u>\$15,700</u></del>	<u>)</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
Health care provider's office or	Other practitioner office visit	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
clinic visit	Specialist visit	<del>\$80<u>\$85</u></del>		<del>\$80<u>\$85</u></del>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
<b>F</b> acto					
Tests	X-rays and Diagnostic Imaging	<del>\$75<u>\$85</u></del>		<del>\$75<u></u>\$85</del>	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	<del>\$15</del> <u>\$17</u>	Pharmacy deductible	<del>\$15</del> <u>\$17</u>	Pharm deduct
			Pharmacy		Pharm
Drugs to reat illness	Tier 2	<del>\$55</del> <u>\$65</u>	deductible	<del>\$55</del> <u>\$65</u>	deduct
or condition	Tier 3	<u>\$85\$90</u>	Pharmacy	<del>\$85<u>\$90</u></del>	Pharm
			deductible		deduct
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharm deduct
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	<del>\$350</del> \$400	X	<del>\$350<u>\$</u>400</del>	<u>×</u>
Need	Emergency room physician fee (waived if admitted)		_		_
mmediate		No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	×	\$250	×
	Urgent care	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х	20%	х
	Physician/surgeon fee	20%	Х	20%	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	<del>\$45</del> <u>\$50</u>		<del>\$45</del> <u>\$50</u>	
behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
	Prenatal care and preconception visits	No chargo		No chargo	
Pregnancy		No charge		No charge	
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$45 <u>\$50</u>		\$45 <u>\$50</u>	
ecovering or other special	Skilled nursing care	20%	х	20%	x
nealth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See <del>20192020</del> Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		See <u>20192020</u> Dental Copay Schedule	
00111003					
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See 20192020 Dental Copay Schedule	
Services	Prosthodontics				

50%

\$1,000

CCSB-only Summary of Benefits and Coverage Silver HDHP Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator <del>70.5<u>71.3</u>%</del> Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2,500 integrated \$5,000 integrated Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A Individual Out-of-pocket maximum <del>\$6,650<u>\$6,850</u></del> Family Out-of-pocket maximum \$13,300<u>\$13,700</u> HSA plan: Self-only coverage deductible \$2,500 HSA family plan: Individual deductible See endnote Common Member Cost Share Deductible Applie Medical Service Type Event Primary care visit to treat an injury, illness, or condition 20% Х Health care Other practitioner office visit 20% provider's Х office or clinic visit Specialist visit 20% Х Preventive care/ screening/ immunization No charge Laboratory Tests 20% Х X-rays and Diagnostic Imaging Tests 20% х Imaging (CT/PET scans, MRIs) 20% Х 20% up to \$250 per Tier 1 Х script 20% up to \$250 per Tier 2 х Drugs to . script treat illness 20% up to \$250 per or condition Tier 3 Х script 20% up to \$250 per Tier 4 Х script Surgery facility fee (e.g., ASC) 20% Х Outpatient Physician/surgeon fees 20% х . services Outpatient visit 20% Х Emergency room facility fee (waived if admitted) 20% Х Emergency room physician fee (waived if admitted) Need 0% Х immediate attention Medical transportation (including emergency and non-emergency) 20% Х Urgent care 20% Х Facility fee (e.g. hospital room) for inpatient stay (including labor and 20% х delivery, mental health, and substance use) Hospital stay Physician/surgeon fee 20% Х Mental Mental/behavioral health and substance use disorder outpatient office health, 20% Х visits behavioral health, or substance Mental/behavioral health and substance use disorder other outpatient 20% х items and services abuse needs Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) 20% Х Outpatient Rehabilitation and Habilitation services 20% Х Help . recovering or Skilled nursing care 20% Х other special health needs Durable medical equipment 20% Х Hospice service 0% Х Eve exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental **Restorative Procedures** Basic Services 20% Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Major Services Periodontics (other than maintenance) 50% Prosthodontics Oral Surgery Child Medically necessary orthodontics 50% Orthodo

### Date: March 15, 2018 February 21, 2019

Oral Surgery

Medically necessary orthodontics

Child Orthodontics

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan	
Actuarial Value - A	V Calculator	100%-150 <sup>4</sup> <del>94.2<u>94.</u></del>		150%-200% FPL <del>87.987.7</del> %	
	Plan design includes a deductible?	Yes, Medical/F		Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 <u>\$1,400</u> / \$50 <u>\$100</u>	<u>)</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	<del>\$1,300<u>\$2,800</u> / <del>\$100<u>\$2</u></del></del>	<u>00</u> / \$0
	Individual Out-of-pocket maximum	\$1,00	0	<del>\$2,600<u>\$2,700</u></del>	
	Family Out-of-pocket maximum	\$2,00	0	<del>\$5,200<u></u>\$5,400</del>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or					
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		<del>\$15<u></u>\$20</del>	
Tests	X-rays and Diagnostic Imaging	\$8		<del>\$30<u>\$40</u></del>	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
	Tier 2	¢10		\$20\$25	Pharmacy
Drugs to treat illness		\$10		<del>\$20<u>\$25</u></del>	deductible
or condition	Tier 3	\$15		<del>\$35<u>\$</u>45</del>	Pharmacy deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		15%	deddelibie
Outpatient	Physician/surgeon fees	10%		15%	
services	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)				
Maria		\$50		<u>\$100\$150</u>	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$30	×	\$75	×
	Urgent care	\$5		\$15	
Heenitel etc.	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	х	15%	х
Hospital stay	Physician/surgeon fee	10%		15%	
Mental	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
health, behavioral	visits	φ <del>ο</del>		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$5		\$15	
abuse needs	items and services	φο		φīσ	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%	х	15%	х
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
	Eye exam	_		_	
Child eye care		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth			-	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	000/		000/	
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				

50%

50%

uninary of Bei	nefits and Coverage	Silver Dien	
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	-
ctuarial Value - A	V Calculator	<del>73.9<u>73.8</u>%</del>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$2,200</del> \$3,700 / <del>\$175<u>\$2</u></del>	7 <u>5</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$4,400<u>\$7,400</u> / <del>\$350<u>\$5</u></del></del>	<u>50</u> / \$0
	Individual Out–of–pocket maximum	<del>\$6,300<u>\$6,550</u></del>	
	Family Out-of-pocket maximum	<del>\$12,600</del> <u>\$13,100</u>	!
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's office or	Other practitioner office visit	\$35	
clinic visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$ <u>35\$40</u>	
Tests	X-rays and Diagnostic Imaging	<del>\$75<u>\$85</u></del>	
	, , , , , , , , , , , , , , , , , , , ,		
	Imaging (CT/PET scans, MRIs)	<del>\$300<u>\$325</u></del>	Phore
	Tier 1	\$ <del>15</del> <u>\$16</u>	Pharma deductit
Drugs to treat illness	Tier 2	\$ <del>5</del> 0 <u>\$55</u>	Pharma deductit
or condition	Tier 3	<del>\$75<u></u>\$85</del>	Pharma deductit
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductit
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	<u>\$350<u>\$400</u></u>	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	×
	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	х
Hospital stay	delivery, mental health, and substance use)		
Mental	Physician/surgeon fee	20%	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
recovering or	Skilled nursing care	20%	х
other special health needs			^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
Ohild Device	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child			

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	
tuarial Value - A'	V Calculator	<del>60.9<u>61.3</u>%</del>		<del>61.6<u>62.0</u>%</del>	
	Plan design includes a deductible?	Plan design includes a deductible? Yes, Medical/Pharmacy Yes, integra		ated	
	Integrated Individual deductible	N/A		\$ <del>6,000<u>\$6,950</u> in</del>	-
	Integrated Family deductible	N/A		<del>\$12,000<u>\$13,900</u> i</del>	integrate
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$		N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 /	\$0	N/A	
	Individual Out-of-pocket maximum	\$ <del>7,550</del> <u>\$7,850</u>		\$ <del>6,650<u>\$6,9</u></del>	
	Family Out-of-pocket maximum	\$ <u>15,100\$15,700</u>	2	\$ <del>13,300</del> <u>\$13</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			<del>\$6,000<u>\$6,9</u> \$6,000<u>\$6,9</u></del>	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appli
Event	Primary care visit to treat an injury, illness, or condition	\$75 <u>\$65</u>	After 1st three non-	40% <u>0%</u>	Х
Health care			preventive visits After 1st three non-		
provider's office or	Other practitioner office visit	<del>\$75</del> <u>\$65</u>	preventive visits	4 <del>0%<u>0%</u></del>	X
clinic visit	Specialist visit	<del>\$105<u>\$95</u></del>	After 1st three non- preventive visits	4 <del>0%</del> 0%	x
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		4 <del>0%<u>0%</u></del>	X
Tests	X-rays and Diagnostic Imaging	<del>100%40%</del>	x	4 <del>0%<u>0%</u></del>	x
	Imaging (CT/PET scans, MRIs)	<del>100%</del> 40%	X	40%0%	x
		100% up to \$500 per script after		40% up to \$500	
	Tier 1	pharmacy deductible <u>\$18</u>	Pharmacy Deductible	per script <u>0%</u>	X
Drugs to	Tier 2	100%40% up to \$500 per script after	Pharmacy Deductible	4 <del>0% up to \$500</del>	x
reat illness	T. (	pharmacy deductible 100%40% up to \$500 per script after	Deductible Pharmacy	per script <u>0%</u> 40% up to \$500	
or condition	Tier 3	pharmacy deductible	Deductible	per script <u>0%</u>	X
	Tier 4	100%40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	4 <del>0% up to \$500</del> per script <u>0%</u>	×
	Surgery facility fee (e.g., ASC)	100%40%	X	40%0%	x
Outpatient	Physician/surgeon fees				
ervices	, ,	<del>100%<u>40%</u></del>	х	4 <del>0%<u>0%</u></del>	X
	Outpatient visit	<del>100%<u>40%</u></del>	Х	4 <del>0%<u>0%</u></del>	X
	Emergency room facility fee (waived if admitted)	<del>100%<u>40%</u></del>	Х	4 <del>0%<u>0%</u></del>	×
veed mmediate	Emergency room physician fee (waived if admitted)	No charge		0%	X
attention	Medical transportation (including emergency and non-emergency)	<del>100%<u>40%</u></del>	Х	4 <del>0%<u>0%</u></del>	×
	Urgent care	<del>\$75</del> <u>\$65</u>	After 1st three non- preventive visits	4 <del>0%<u>0%</u></del>	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	<del>100%40%</del>	X	4 <del>0%</del> 0%	x
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	<del>100%<u>40%</u></del>	Х	4 <del>0%<u>0%</u></del>	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	<del>\$75<u>\$65</u></del>	After 1st three non- preventive visits	4 <del>0%<u>0%</u></del>	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>\$75<u>\$65</u></del>	x	4 <del>0%<u>0%</u></del>	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	<del>100%<u>40%</u></del>	х	4 <del>0%</del> 0%	X
lelp	Outpatient Rehabilitation and Habilitation services	<del>\$75</del> <u>\$65</u>		<del>40%</del> 0%	x
ecovering or			~		
other special nealth needs	Skilled nursing care	<del>100%<u>40%</u></del>	Х	4 <del>0%<u>0%</u></del>	X
	Durable medical equipment	<del>100%<u>40%</u></del>	Х	4 <del>0%<u>0%</u></del>	X
	Hospice service	No charge		0%	×
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
bild Dentel	•				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
		I			1

immary of Be	nefits and Coverage		
mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
tuarial Value - A			
	Plan design includes a deductible?		integrated
	Integrated Individual deductible		,200 integrated
	Integrated Family deductible	<del>\$15,800<u>\$1</u></del>	6,400 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	07.0	N/A
	Individual Out-of-pocket maximum		000 <u>\$8,200</u>
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	<del>\$10,</del> 6	800 <u>\$16,400</u> N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Lvon	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no preventive visits
Health care provider's office or	Other practitioner office visit	0%	After 1st three no preventive visits
clinic visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	х
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	x
Drugs to	Tier 2	0%	х
treat illness or condition	Tier 3	0%	х
	Tier 4	0%	x
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient	Physician/surgeon fees	0%	X
services	Outpatient visit	0%	x
	Emergency room facility fee (waived if admitted)	0%	Х
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	0%	X After 1st three no
	Urgent care	0%	preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	Х
Hospital stay	Physician/surgeon fee	0%	х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visits
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Holp	Outpatient Rehabilitation and Habilitation services	0%	x
Help recovering or	•		
other special health needs	Skilled nursing care	0%	Х
	Durable medical equipment	0%	Х
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
Child Devis	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	no chaige	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
-	Periodontal Maintenance Services	0%	Х
Basic Services			
	Crowns and Casts		
	Crowns and Casts Endodontics		
Services Child Dental	Endodontics	0%	¥
Services	Endodontics Periodontics (other than maintenance)	0%	x
Services Child Dental Major	Endodontics	0%	Х

9.5 EHB Date: March 15, 2018February 21, 2019



immary of Ken	efits and Coverage		1			
-	nary of Benefits and Coverage r Cost Share amounts describe the Enrollee's out of pocket costs.		Plan	Platinum Copay Plan		
tuarial Value - A	/ Calculator	Coinsurance 91.7%		88.989.1		
	Plan design includes a deductible?	No		No		
	Integrated Individual deductible	\$0		\$0		
	Integrated Family deductible	\$0		\$0		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	D	\$0 / \$0 / \$	0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	D	\$0 / \$0 / \$	0	
	Individual Out-of-pocket maximum	\$ <del>3,350<u>\$4,5</u></del>	<u>00</u>	\$ <del>3,350<u>\$4,5</u></del>	<u>00</u>	
	Family Out-of-pocket maximum	<del>\$6,700<u></u>\$9,0</del>	<u>00</u>	<del>\$6,700<u></u>\$9,0</del>	<u>00</u>	
	HSA plan: Self-only coverage deductible	N/A		N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie	
	Primary care visit to treat an injury, illness, or condition	\$15		\$15		
Health care provider's office or	Other practitioner office visit	\$15		\$15		
clinic visit	Specialist visit	\$30		\$30		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$15		\$15		
rests	X-rays and Diagnostic Imaging	\$30		\$30		
	Imaging (CT/PET scans, MRIs)	10%		\$75		
	Tier 1	\$5		\$5		
Drugs to treat	Tier 2	\$15		\$15		
liness or						
condition	Tier 3	\$25		\$25		
	Tier 4	10% up to \$250 per script		10% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	10%		\$100		
Dutpatient services	Physician/surgeon fees	10%		\$25		
	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$150		\$150		
Need	Emergency room physician fee (waived if admitted)	No charge		No charge		
immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150		
	Urgent care	\$15		\$15		
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$250 per day up to		
lospital stay	delivery, mental health, and substance use)	10%		5 days		
	Physician/surgeon fee	10%		No charge		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15		
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	10%		\$20		
lelp ecovering or	Outpatient Rehabilitation and Habilitation services	\$15		\$15 \$150 per day up to		
other special nealth needs	Skilled nursing care	10%		5 days		
leanth needs	Durable medical equipment	10%		10%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic		Not Covered		Not Covered		
Services	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	Not Covered		Not Covered		

#### Date: March 15, 2018 February 21, 2019

Oral Surgery

Medically necessary orthodontics

Child Orthodontic

Summary of Benefits and Coverage

Individual-only Gold Individual-only Gold Member Cost Share amounts describe the Enrollee's out of pocket costs Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 81.881.9% 78.178.3% Plan design includes a deductible? No No \$0 \$0 Integrated Individual deductible Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Individual Out-of-pocket maximum <del>\$7,200<u>\$7,850</u></del> \$<del>7,200<u>\$7,850</u></del> <del>\$14,400<u>\$15,700</u></del> Family Out-of-pocket maximum <del>\$14,400<u>\$15,700</u></del> HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Medical Event Member Cost Share Deductible Applies Deductible Applies Member Cost Service Type Primary care visit to treat an injury, illness, or condition \$30 \$30 Health care provider's office or Other practitioner office visit \$30 \$30 clinic visit <u>\$55\$60</u> <u>\$55\$60</u> Specialist visit Preventive care/ screening/ immunization No charge No charge Laboratory Tests <del>\$35<u>\$40</u></del> <del>\$35</del>\$40 Tests X-rays and Diagnostic Imaging <del>\$55</del>\$75 <del>\$55</del>\$75 Imaging (CT/PET scans, MRIs) \$275 20% Tier 1 \$15 \$15 Tier 2 \$55 \$55 Drugs to treat illness or condition Tier 3 <del>\$75<u>\$80</u></del> <del>\$75<u>\$80</u></del> 20% up to \$250 per 20% up to \$250 per Tier 4 script Surgery facility fee (e.g., ASC) 20% \$300 Outpatient Physician/surgeon fees 20% \$40 services Outpatient visit 20% 20% Emergency room facility fee (waived if admitted) <del>\$325<u></u>\$350</del> <del>\$325<u></u>\$350</del> Need Emergency room physician fee (waived if admitted) No charge No charge immediate Medical transportation (including emergency and non-emergency) \$250 \$250 attention Urgent care \$30 \$30 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) \$600 per day up to 5 days 20% Hospital stay Physician/surgeon fee 20% No charge Mental/behavioral health and substance use disorder outpatient office Mental health, \$30 \$30 visits behavioral health. or substance Mental/behavioral health and substance use disorder other outpatient \$30 \$30 abuse needs items and services Prenatal care and preconception visits No charge No charge Pregnancy Home health care (cost share per visit) 20% \$30 Outpatient Rehabilitation and Habilitation services \$30 \$30 Help recovering or \$300 per day up to Skilled nursing care 20% other special health needs 5 days Durable medical equipment 20% 20% Hospice service No charge No charge No charge No charge Eye exam Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic Not Covered Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Not Covered Basic Periodontal Maintenance Services Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) Not Covered Not Covered Major Services Prosthodontics

Not Covered

Not Covered

Date: March 15, 2018 February 21, 2019

mber Cost Share a	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Plat 81.878 1%	n	CCSB-only Gold Copay Plan 78-170-7%	
tuarial Value - AV	/ Calculator Plan design includes a deductible?	<del>81.8<u>78.1</u>% NoYes, Medical/Pharr</del>	macy	<del>78.1<u>79.7</u>% No</del> Yes, Medical/Pha	rmaov
	Integrated Individual deductible	son/A	nacy	so <u>N/A</u>	macy
	Integrated Individual deductible	\$0 <u>N/A</u>		\$0 <u>N/A</u>	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$0<u>\$250</u> / \$0 / \$0   \$0   \$0   \$0   \$0   \$0   \$0</del>		\$0 <u>\$0\$250</u> / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$500</u> / \$0 / \$0		\$0\$500 / \$0 / \$	
	Individual Out–of–pocket maximum	\$ <del>7,200</del> \$7,850		\$ <del>7,200</del> \$7,850	
	Family Out-of-pocket maximum	<del>\$14,400<u>\$15,700</u></del>		<del>\$14,400</del> \$15,70	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	<del>\$30<u>\$25</u></del>		<del>\$30</del> <u>\$25</u>	
Health care provider's	Other practitioner office visit	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
office or clinic visit	Specialist visit	<u>\$55\$50</u>		\$ <del>55</del> <u>\$50</u>	
	Preventive care/ screening/ immunization				
-	Laboratory Tests	No charge <del>\$35<u>\$25</u></del>		No charge <u>\$35<u></u>\$25</u>	
Tests	X-rays and Diagnostic Imaging	<del>\$55</del> <u>\$65</u>		\$55 <u>\$65</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat Ilness or	Tier 2	<del>\$5</del> 5 <u>\$50</u>		<del>\$5</del> 5 <u>\$50</u>	
condition	Tier 3	<del>\$75<u>\$80</u></del>		<del>\$75<u>\$80</u></del>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
501 11005	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	<del>\$325</del> <u>\$250</u>	X	<del>\$325</del> \$250	<u>×</u>
Need	Emergency room physician fee (waived if admitted)	No charge	_	No charge	_
immediate		-			
attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	<u>×</u>	\$600 per day up to 5 days	<u>×</u>
ricopital otay	Physician/surgeon fee	20%	X	No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	<del>20%<u>\$30</u></del>		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services	<del>\$30<u>\$25</u></del>		<del>\$30<u>\$25</u></del>	
other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
Dhild David	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
Child Dontal				Not Covered	
Major	Periodontics (other than maintenance)	Not Covered			
Major	Periodontics (other than maintenance) Prosthodontics	Not Covered		Not Obvered	
Child Dental Major Services		Not Covered			

Date: March 15, 2018 February 21, 2019

	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
tuarial Value - AV	/ Calculator	<del>71.8<u>71.7</u>%</del>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$2,500<u>\$4,000</u> / <u>\$200<u>\$3</u></u></del>	<u>00</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<u>\$5,000</u> \$8,000 / \$400 <u>\$6</u>	<u>00</u> / \$0
	Individual Out-of-pocket maximum	<del>\$7,550<u>\$7,850</u></del>	
	Family Out-of-pocket maximum	<del>\$15,100<u>\$15,700</u></del>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common			Deductit
Medical Event	Service Type	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$40	
provider's office or	Other practitioner office visit	\$40	
clinic visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	<del>\$35</del> <u>\$40</u>	
Tests	X-rays and Diagnostic Imaging	<del>\$75</del> <u>\$85</u>	
	Imaging (CT/PET scans, MRIs)	<del>\$300<u></u>\$325</del>	
	Tier 1	<del>\$15<u>\$16</u></del>	Pharma deductit
Drugs to treat	Tier 2	\$55 <u>\$60</u>	Pharma deductit
illness or condition	Tier 3	<del>\$80<u>\$90</u></del>	Pharma deductit
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma
	Surgery facility fee (e.g., ASC)	20%	ucuucii
Outpatient services	Physician/surgeon fees	20%	
301 11003	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	<del>\$350</del> \$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	×
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	20%	Х
	Physician/surgeon fee	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	<b>0</b> 40	
abuse needs	items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$40	
recovering or other special	Skilled nursing care	20%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
00111005	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

ummary of Benefits and Coverage ember Cost Share amounts describe the Enrollee's out of pocket costs. ctuarial Value - AV Calculator		CCSB <u>-only</u> Silver		CCSB <u>-only</u> Silver		
		Coinsurance Plan 71.970.5%		Copay Plan <del>71.670.2</del> %		
luariar value - Av						
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy	
	Integrated Individual deductible	N/A		N/A		
	Integrated Family deductible	N/A		N/A	00 / 00	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$2,000<u>\$2,250</u> / <u>\$200<u>\$30</u></u></del>		\$ <del>2,000</del> <u>\$2,250</u> / <del>\$200</del> <u>\$3</u>		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 <u>\$4,500</u> / \$400 <u>\$600</u> / \$0		\$4,000 <u>\$4,500</u> / \$400 <u>\$600</u> / \$0		
	Individual Out-of-pocket maximum	<del>\$7,550<u>\$7,850</u></del>		<del>\$7,550<u>\$7,850</u></del>		
	Family Out-of-pocket maximum	<del>\$15,100<u></u>\$15,700</del>		<del>\$15,100</del> <u>\$15,700</u>		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A		
Common			Deductible		Deducti	
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applie	
Health care	Primary care visit to treat an injury, illness, or condition	\$45 <u>\$50</u>		\$45 <u>\$50</u>		
provider's	Other practitioner office visit	\$45 <u>\$50</u>		\$45 <u>\$50</u>		
office or clinic visit	Specialist visit	<del>\$80<u>\$</u>85</del>		<del>\$80<u>\$</u>85</del>		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$40		\$40		
ests	X-rays and Diagnostic Imaging	<del>\$75<u>\$85</u></del>		<del>\$75<u>\$85</u></del>		
	Imaging (CT/PET scans, MRIs)	20%		\$300		
	Tier 1	<del>\$15</del> <u>\$17</u>	Pharmacy	<del>\$15</del> <u>\$17</u>	Pharm	
			deductible Pharmacy		deduct Pharm	
Drugs to treat liness or	Tier 2	<del>\$5</del> 5 <u>\$65</u>	deductible	<del>\$5</del> 5 <u>\$65</u>	deduct	
ondition	Tier 3	<del>\$85<u>\$90</u></del>	Pharmacy	<del>\$85<u>\$90</u></del>	Pharm	
			deductible		deduct	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharm deduct	
	Surgery facility fee (e.g., ASC)	20%		20%		
Dutpatient	Physician/surgeon fees	20%		20%		
ervices						
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	<u>\$350\$400</u>	X	<u>\$350\$400</u>	<u>X</u>	
Need immediate attention	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Medical transportation (including emergency and non-emergency)	\$250	×	\$250	×	
	Urgent care	\$45 <u>\$50</u>		\$45 <u>\$50</u>		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
lospital stay	delivery, mental health, and substance use)	20%	Х	20%	Х	
	Physician/surgeon fee	20%	Х	20%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$45 <u>\$50</u>		\$45 <u>\$50</u>		
pehavioral nealth, or	visits	\$ 10 <u>000</u>		\$ 10 <u>900</u>		
substance	Mental/behavioral health and substance use disorder other outpatient	<b>0</b> 45050		0.45050		
abuse needs	items and services	\$4 <u>5</u> \$50		\$4 <u>5</u> \$50		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$45		
lelp	Outpatient Rehabilitation and Habilitation services	<del>\$45<u></u>\$50</del>		<del>\$45<u></u>\$50</del>		
ecovering or other special	Skilled nursing care	20%	х	20%	х	
ealth needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
child Dental	Preventive - X-ray					
)iagnostic Ind		Not Covered		Not Covered		
reventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					

Date: March 1	<del>5, 2018<u>February 21, 2019</u></del>			
•	nefits and Coverage	CCSB <u>-0</u> Silver		
Member Cost Share amounts describe the Enrollee's out of pocket costs. HDHP Plan				
Actuarial Value - AV	V Calculator	<del>70.5<u>71.</u>3</del>	<u>3</u> %	
	Plan design includes a deductible?	Yes, integrated		
	Integrated Individual deductible \$2,500 integrat		grated	
	Integrated Family deductible	\$5,000 inte	grated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	050	
	Individual Out-of-pocket maximum	<del>\$6,650<u>\$6</u> \$13,300</del> \$1		
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$2,500		
	HSA family plan: Individual deductible	See endr		
Common				
Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	20%	х	
Health care provider's	Other practitioner office visit	20%	х	
office or clinic visit	Chapielist visit	200/	Y	
chine visit	Specialist visit	20%	X	
_	Preventive care/ screening/ immunization	No charge	v	
Tosta	Laboratory Tests	20%	x	
Tests	X-rays and Diagnostic Imaging	20%		
	Imaging (CT/PET scans, MRIs)	20%	Х	
	Tier 1	20% up to \$250 per script	Х	
Drugs to treat	Tier 2	20% up to \$250 per	x	
illness or condition	Tier 3	script 20% up to \$250 per	x	
	Tier 4	script 20% up to \$250 per	x	
		script		
Outpatient	Surgery facility fee (e.g., ASC)	20%	Х	
services	Physician/surgeon fees	20%	Х	
	Outpatient visit	20%	Х	
	Emergency room facility fee (waived if admitted)	20%	Х	
Need immediate	Emergency room physician fee (waived if admitted)	0%	х	
attention	Medical transportation (including emergency and non-emergency)	20%	х	
	Urgent care	20%	x	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	х	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	x	
		2070	~	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	х	
health, or substance				
abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	Х	
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	20%	х	
Help	Outpatient Rehabilitation and Habilitation services	20%	х	
recovering or other special	Skilled nursing care	20%	x	
health needs	Durable medical equipment	20%	x	
	Hospice service	0%	x	
	Eye exam		^	
Child eye care	Lye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam	No charge		
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray	Not Covered		
Preventive	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services			
	Crowns and Casts			
Child Dental	Endodontics			
Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	Not Covered		
Orthodontics				

#### Date: March 15, 2018 February 21, 2019

Child Orthodontics

Medically necessary orthodontics

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
tuarial Value - A	/ Calculator	<del>94.2<u>94.</u>8</del>		<del>87.9<u>87.7</u>%</del>	
	Plan design includes a deductible?	Yes, Medical/F	harmacy	Yes, Medical/Pharma	асу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	<del>\$650<u>\$1,400</u> / <del>\$50<u>\$100</u></del></del>	<mark>)</mark> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$ <del>1,300</del> <u>\$2,800</u> / <del>\$100</del> <u>\$2(</u>	<mark>00</mark> / \$0
	Individual Out-of-pocket maximum	\$1,000	)	<del>\$2,600<u>\$2,700</u></del>	
	Family Out-of-pocket maximum	\$2,000	)	<del>\$5,200<u>\$5,400</u></del>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
_	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	· Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$15 <u>\$20</u>	
Tests	X-rays and Diagnostic Imaging	\$8		\$30 <u>\$40</u>	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
		\$3		\$100	
					Pharma
Drugs to treat	Tier 2	\$10		<del>\$20<u>\$25</u></del>	deducti Pharma
condition	Tier 3	\$15		\$ <del>35</del> \$45	deducti
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharma deducti
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$100 <u>\$150</u>	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$30	×	\$75	×
attention	Urgent care	\$5	~	\$15	A
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	φo		\$15	
Hospital stay	delivery, mental health, and substance use)	10%	Х	15%	Х
	Physician/surgeon fee	10%		15%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Holp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or			v		
other special health needs	Skilled nursing care	10%	Х	15%	Х
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Net Original		Net Or much	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic	Periodontal Maintenance Services	Not Covered		Not Covered	
Services					
	Crowns and Casts				
Child Dental					
Child Dental	Endodontics				
Major	Endodontics Periodontics (other than maintenance)	Not Covered		Not Covered	
		Not Covered		Not Covered	

Not Covered

Not Covered

Date: March 15, 2018 February 21, 2019 Summary of Benefits and Coverage

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	<b>Silver Plan</b> 200%-250% FPI	-
uarial Value - AV	/ Calculator	<del>73.9<u>73.8</u>%</del>	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$2,200</del> \$3,700 / <del>\$175<u>\$2</u></del>	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,400 <u>\$7,400</u> / \$350 <u>\$5</u>	50 / \$0
	Individual Out-of-pocket maximum	<del>\$6,300<u>\$6,550</u></del>	
	Family Out-of-pocket maximum	<del>\$12,600</del> <u>\$13,100</u>	<u>)</u>
	HSA plan: Self-only coverage deductible	N/A N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$35	
provider's	Other practitioner office visit	\$35	
clinic visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	<del>\$35<u></u>\$40</del>	
Tests	X-rays and Diagnostic Imaging	<del>\$75</del> <u>\$85</u>	
	Imaging (CT/PET scans, MRIs)	<del>\$300</del> <u>\$325</u>	
	Tier 1	<del>\$15<u>\$</u>16</del>	Pharmac
			deductib Pharma
Drugs to treat Ilness or	Tier 2	<del>\$50<u></u>\$55</del>	deductib
condition	Tier 3	<del>\$75</del> <u>\$85</u>	Pharma
		20% up to \$250 per script	deductib Pharma
	Tier 4	after pharmacy deductible	deductib
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	<del>\$350</del> \$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
mmediate	Medical transportation (including emergency and non-emergency)	\$250	×
attention	Urgent care		~
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$35	
Hospital stay	delivery, mental health, and substance use)	20%	Х
	Physician/surgeon fee	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Progranov	Prenatal care and preconception visits	No oborgo	
Pregnancy		No charge	
	Home health care (cost share per visit)	\$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35	
other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	-	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive			
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dontal	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
	- · ·		

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan	Bronze HDHP Plan		
Actuarial Value - AV Calculator		<del>60.9<u>61.3</u>%</del>	61.6 <u>62.0</u> %		
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, integrated	
	Integrated Individual deductible	N/A		\$6,000 <u>\$6,950</u> integrate	
	Integrated Family deductible			\$12,000 <u>\$13,900</u> integra	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	\$O	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000	/ \$0	N/A	
	Individual Out–of–pocket maximum	<del>\$7,550<u>\$7,850</u></del>		\$ <del>6,650</del> <u>\$6,950</u>	
	Family Out-of-pocket maximum	<del>\$15,100<u>\$15,70</u></del>	<u>0</u>	\$13,300 <u>\$13</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		<del>\$6,000<u>\$6,</u>9 \$6,000<u>\$6,9</u></del>	
Common				Member Cost	Deductit
Medical Event	Service Type	Member Cost Share	Deductible Applies	Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	<del>\$75</del> <u>\$65</u>	After 1st three non- preventive visits	4 <del>0%<u>0%</u></del>	X
provider's	Other practitioner office visit	<del>\$75</del> <u>\$65</u>	After 1st three non- preventive visits	4 <del>0%<u>0%</u></del>	x
office or clinic visit	Specialist visit	<del>\$105</del> \$95	After 1st three non-	<del>40%</del> 0%	x
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge	
	Laboratory Tests	\$40		40%0%	x
Tests	X-rays and Diagnostic Imaging	<del>40</del> <del>100%</del> 40%	x	<del>40%<u>0%</u> 40%</del> 0%	x
	Imaging (CT/PET scans, MRIs)	100%40%	X	40% <u>0%</u>	x
			^	40% <u>0%</u> 40% up to \$500	
	Tier 1	100% up to \$500 per script after pharmacy deductible <u>\$18</u>	Pharmacy Deductible	<del>40% up to \$500</del> per script <u>0%</u>	X
Drugs to treat	Tier 2	100%40% up to \$500 per script	Pharmacy	40% up to \$500	x
illness or		after pharmacy deductible 100%40% up to \$500 per script	Deductible Pharmacy	per script <u>0%</u> 4 <del>0% up to \$500</del>	
condition	Tier 3	after pharmacy deductible	Deductible	per script <u>0%</u>	X
	Tier 4	100%40% up to \$500 per script	Pharmacy	40% up to \$500	x
		after pharmacy deductible	Deductible	per script <u>0%</u>	
Outpatient	Surgery facility fee (e.g., ASC)	<del>100%<u>40%</u></del>	X	4 <del>0%</del> 0%	Х
services	Physician/surgeon fees	<del>100%<u>40%</u></del>	Х	<del>40%<u>0%</u></del>	X
	Outpatient visit	<del>100%<u>40%</u></del>	Х	4 <del>0%<u>0%</u></del>	Х
	Emergency room facility fee (waived if admitted)	<del>100%<u>40%</u></del>	х	4 <del>0%<u>0%</u></del>	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge		0%	x
attention	Medical transportation (including emergency and non-emergency)	<del>100%<u>40%</u></del>	х	4 <del>0%<u>0%</u></del>	x
	Urgent care	<del>\$75</del> <u>\$65</u>	After 1st three non- preventive visits	4 <del>0%<u>0%</u></del>	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	<del>100%</del> 40%	X	<del>40%</del> 0%	x
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	<del>100%<u>40%</u></del>	X	<del>40%<u>0%</u></del>	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	<del>\$75</del> <u>\$65</u>	After 1st three non- preventive visits	4 <del>0%<u>0%</u></del>	x
health, or			proventive viole		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>\$75</del> <u>\$65</u>	x	<del>40%<u>0%</u></del>	x
_					
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	<del>100%<u>40%</u></del>	Х	4 <del>0%</del> 0%	X
Help	Outpatient Rehabilitation and Habilitation services	<del>\$75</del> <u>\$65</u>		4 <del>0%</del> 0%	x
recovering or other special	Skilled nursing care	<del>100%</del> 40%	x	4 <del>0%<u>0%</u></del>	x
health needs	Durable medical equipment	<del>100%</del> 40%	x	<del>40%</del> 0%	x
	Hospice service	No charge		0%	x
	Eye exam	No charge		No charge	~
Child eye care		-		-	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services	, ,			NUL COVETED	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

	amounts describe the Enrollee's out of pocket costs.	Catast	trophic Plan
tuarial Value - A			
	Plan design includes a deductible?		integrated
	·	Integrated Individual deductible \$7,900 <u>\$8,20</u>	
	Integrated Family deductible		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	¢7.0	N/A
	Individual Out–of–pocket maximum		000 <u>\$8,200</u>
	Family Out-of-pocket maximum	<del>\$ 13,</del> 8	<del>300<u>\$16,400</u> N/A</del>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A
Common	Service Type	Member Cost	Deductible Applie
Medical Event	Primary care visit to treat an injury, illness, or condition	Share 0%	After 1st three no
Health care provider's	Other practitioner office visit	0%	preventive visit
office or clinic visit		00/	preventive visit
cimic visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	Х
	Tier 1	0%	х
Drugs to treat illness or	Tier 2	0%	х
condition	Tier 3	0%	х
	Tier 4	0%	х
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient services	Physician/surgeon fees	0%	Х
	Outpatient visit	0%	х
	Emergency room facility fee (waived if admitted)	0%	х
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate	Medical transportation (including emergency and non-emergency)	0%	х
attention			After 1st three no
_	Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	preventive visit
Hospital stay	delivery, mental health, and substance use)	0%	Х
	Physician/surgeon fee	0%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visit
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	x
abuse needs	items and services	0%	^
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	х
recovering or other special	Skilled nursing care	0%	х
health needs	Durable medical equipment	0%	х
	Hospice service	0%	x
	Eye exam		^
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	х
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive			
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

## Endnotes to Covered California 2019-2020 Patient-Centered Benefit Plan Designs

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

### Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2019 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. 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.
- Member cost-share for oral anti-cancer drugs shall not exceed \$200-250 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California <u>2019-2020</u> Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a

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

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

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

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

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

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