Covered California 2020 Patient-Centered Benefit Plan Designs¹

Final Board-approved Proposed March 14 May 16, 2019

¹ These are the Standard Benefit Plan Designs pursuant to Government Code Section 100504(c).

10.0 EHB

Date: March 14, 2019 May 16, 2019
Summary of Benefits and Coverage



Member Cost Share amounts describe the Enrollee's out of pocket costs Copay Plan Actuarial Value - AV Calculator 89.1% Plan design includes a deductible? No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Individual Out-of-pocket maximum \$4,500 \$4,500 Family Out-of-pocket maximum \$9,000 \$9,000 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Member Cost Member Cost Deductible Applies Deductible Applies Service Type Medical Primary care visit to treat an injury, illness, or condition \$15 \$15 Health care Other practitioner office visit provider's \$15 \$15 office or \$30 clinic visit Specialist visit \$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 Tier 2 \$15 \$15 Drugs to treat illness or condition Tier 3 \$25 \$25 10% up to \$250 per 10% up to \$250 per Tier 4 script script Surgery facility fee (e.g., ASC) 10% \$100 Outpatient Physician/surgeon fees 10% \$25 Outpatient visit 10% 10% Emergency room facility fee (waived if admitted) \$150 \$150 Emergency room physician fee (waived if admitted) Need No charge No charge immediate Medical transportation (including emergency and non-emergency) \$150 \$150 attention Urgent care \$15 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and \$250 per day up to 10% delivery, mental health, and substance use) 5 days Hospital stay Physician/surgeon fee No charge 10% Mental Mental/behavioral health and substance use disorder outpatient office \$15 health, \$15 behavioral health, or Mental/behavioral health and substance use disorder other outpatient \$15 \$15 items and services abuse needs Pregnancy Prenatal care and preconception visits No charge No charge Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$15 Help recovering or \$150 per day up to Skilled nursing care 10% other special health needs 5 days Durable medical equipment 10% 10% Hospice service No charge No charge Eve exam No charge No charge Child eye 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge No charge Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures See 2020 Dental Copay Schedule Basic Services 20% Periodontal Maintenance Services Crowns and Casts Endodontics **Child Dental** See 2020 Dental Major Services Periodontics (other than maintenance) 50% Copay Schedule Prosthodontics Oral Surgery Medically necessary orthodontics 50% \$1,000

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - A	V Calculator	81.9 81.8		78.3%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,80</u>	<u>)0</u>	\$7,850 <u>\$7,8</u>	00
	Family Out-of-pocket maximum	\$ 15,70 0 <u>\$15,6</u>	<u>800</u>	\$15,700 <u>\$15,</u>	<u>600</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	\$30		\$30	
Health care provider's	Other practitioner office visit	\$30		\$30	
office or clinic visit	Specialist visit	\$ 60 \$6 <u>5</u>		\$60 \$65	
	Preventive care/ screening/ immunization				
	Laboratory Tests	No charge \$40		No charge \$40	
Footo	·				
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Orugs to	Tier 2	\$55		\$55	
reat illness or condition	Tier 3	\$80		\$80	
	Hel 3	·		·	
	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	
el vices	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
mmediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention					
	Urgent care	\$30		\$30	
lospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20%		\$600 per day up to 5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
nealth, pehavioral nealth, or	visits	\$30		\$30	
substance abuse 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	
lelp	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
ecovering or other special	Skilled nursing care	20%		\$300 per day up to 5 days	
nealth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - Cleaning Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
N. 11 . 7	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2020 Dental	
Services	Periodontal Maintenance Services			Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See 2020 Dental Copay Schedule	
Services	Prosthodontics			Jopay Concumo	
	Oral Surgery				
Child					

	enefits and Coverage	CCSB-only		CCSB-only		
-	e amounts describe the Enrollee's out of pocket costs.	Gold	•	Gold		
Actuarial Value - A	AV Calculator	Coinsurance Plan	1	Copay Plan 79.679.7 %		
/ totalinal value /	Plan design includes a deductible?	Yes, Medical/Pharma	acy	Yes, Medical/Pharr	nacy	
	Integrated Individual deductible	N/A	,	N/A	.,	
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$250 / \$0 / \$0		\$250 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$500 / \$0 / \$0		\$500 / \$0 / \$0		
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,800</u>		\$7,850 <u>\$7.800</u>		
	Family Out-of-pocket maximum	\$ 15,700 \$15,600		\$15,700 <u>\$15,60</u>	0	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A		
Common	,,,					
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
LVCIIL	Primary care visit to treat an injury, illness, or condition	\$25		\$25		
Health care						
Medical Event Health care provider's office or clinic visit S Tests X In Drugs to treat illness or condition T Outpatient services Need immediate attention Hospital stay Mental health, behavioral health, or	Other practitioner office visit	\$25		\$25		
clinic visit	Specialist visit	\$50		\$50		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$25		
Tests	X-rays and Diagnostic Imaging	\$65		\$65		
	Imaging (CT/PET scans, MRIs)	20%		\$275		
	Tier 1	\$15		\$15		
Druge to	Tier 2	\$50		\$50		
treat illness				·		
or condition	Tier 3	\$80		\$80		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300		
	Physician/surgeon fees	20%		\$40		
services	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	\$250	X	\$250	X	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	x	
attention	Urgent care	\$25		\$25		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		V		V	
Hospital stay	delivery, mental health, and substance use)	20%	Х	\$600 per day up to 5 days	Х	
	Physician/surgeon fee	20%	Х	No charge		
	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$25		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$25		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
riognancy	Home health care (cost share per visit)	\$30		\$30		
	Outpatient Rehabilitation and Habilitation services	\$25		\$25		
Help recovering or						
other special health needs	Skilled nursing care	20%	Х	\$300 per day up to 5 days	X	
	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray	No charge		No charge		
Preventive	Sealants per Tooth					
	Topical Fluoride Application					
Child Day to	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		See 2020 Dental Copay Schedule		
Services	Periodontal Maintenance Services			Jonedale		
	Crowns and Casts					
Child Dental	Endodontics			See 2020 Dental Copay		
Major Services	Periodontics (other than maintenance)	50%		Schedule Schedule		
	Prosthodontics					
Chira	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		

Prosthodontics Oral Surgery

Medically necessary orthodontics

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
ctuarial Value - A	V Calculator	71.7 71.8%	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$	0
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,800</u>	
	Family Out-of-pocket maximum	\$15,700 <u>\$15,600</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	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
. 00.00			
	Imaging (CT/PET scans, MRIs)	\$325	Phormo
	Tier 1	\$16	Pharma deductib
Drugs to	Tier 2	\$60	Pharma deductib
treat illness or condition	Tier 3	\$90	Pharma
	Hel 3		deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
0.4	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$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	000/	X
Hospital stay	delivery, mental health, and substance use)	20%	^
	Physician/surgeon fee	20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
behavioral health, or	Mostal/babayiasal bookh and substance use disorder other sutrations		
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	Skilled nursing care	20%	X
other special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	g	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	20%	
Basic Services	Periodontal Maintenance Services	2070	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		

50%

Summary of Be	nefits and Coverage	CCSB-only		CCSB-only	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plar	1	Silver Copay Plan	
Actuarial Value - A	V Calculator	70.5%		70.2%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$0	
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,800</u>		\$ 7,850 \$ <u>7,800</u>	
	Family Out-of-pocket maximum	\$15,700 <u>\$15,600</u>		\$ 15,700 \$15,600	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common			Deductible		Deductible
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$50		\$50	
provider's office or	Other practitioner office visit	\$50		\$50	
clinic visit	Specialist visit	\$85		\$85	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$85		\$85	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	\$17	Pharmacy deductible	\$17	Pharmacy deductible
Drugs to	Tier 2	\$65	Pharmacy deductible	\$65 \$90	Pharmacy deductible
treat illness or condition	Tier 3	\$90	Pharmacy	\$90	Pharmacy
	Tier 4	20% up to \$250 per script after	deductible Pharmacy	20% up to \$250 per script after	deductible Pharmacy
		pharmacy deductible	deductible	pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%		20%	
services	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
No. of	Emergency room facility fee (waived if admitted)	\$400	X	\$400	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	X
	Urgent care	\$50		\$50	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	20%	X
,,	Physician/surgeon fee	20%	X	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$50	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$50	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$50	
recovering or other special	Skilled nursing care	20%	X	20%	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Ohild	Eye exam	No charge		No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	140 Sharge		140 Sharge	
	Preventive - Cleaning				
Child Dental					
Diagnostic and	Preventive - X-ray Seglante per Tooth	No charge		No charge	
Preventive	Sealants per Tooth Toologi Eliveride Application				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		See 2020 Dental Copay Schedule	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics			See 2020 Dental Copay	
Major Services	Periodontics (other than maintenance)	50%		Schedule	
	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

	1 4, 2019 May 16, 2019 nefits and Coverage	CCSB-o	•
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver HDHP P	
ctuarial Value - A	V Calculator	71.3%)
	Plan design includes a deductible?	Yes, integr	rated
	Integrated Individual deductible	\$2,500 integ	-
	Integrated Family deductible	\$5,000 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	N/A \$6,850	1
	Family Out-of-pocket maximum	\$13,70	
	HSA plan: Self-only coverage deductible	\$2,500	
	HSA family plan: Individual deductible	See endr	
Common Medical Event	Service Type	Member Cost Share	Deductible App
	Primary care visit to treat an injury, illness, or condition	20%	Х
Health care	Other practitioner office visit	20%	×
provider's office or	Street production of those viole	2070	
clinic visit	Specialist visit	20%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	X
Tests	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	Х
	Tier 1	20% up to \$250 per script	×
Drugs to	Tier 2	20% up to \$250 per	X
treat illness	10.2	script	,
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	Physician/surgeon fees		
services		20%	X
	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	X
Need immediate	Emergency room physician fee (waived if admitted)	0%	X
attention	Medical transportation (including emergency and non-emergency)	20%	X
	Urgent care	20%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20% 20%	X X
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	20%	х
behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
ognanoy	Home health care (cost share per visit)	20%	Х
Help recovering or	Outpatient Rehabilitation and Habilitation services	20%	X
other special health needs	Skilled nursing care	20%	X
neam needs	Durable medical equipment	20%	X
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	20%	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
Child Book	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child			

Medically necessary orthodontics

50%

=	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan	
ctuarial Value - A	·	100%-150° 94.5%		150%-200% FPL 87.7%	•
otaanar varao 71	Plan design includes a deductible?	Yes, Medical/F		Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	,	N/A	,
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/\$0	\$1,400 / \$100 / \$6)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$2,800 / \$200 / \$6)
	Individual Out-of-pocket maximum	\$1,00	0	\$2,700	
	Family Out-of-pocket maximum			\$5,400	
	HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common Medical	Service Type	Member Cost	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition			\$15	
Health care	Timely date viole to deat all lightly, limede, or condition	Ψ3		Ψ10	
provider's office or	Other practitioner office visit	\$5		\$15	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
	Tion 2				Pharmacy
Drugs to treat illness	Tier 2	\$10		\$25	deductible
or condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4	10% up to \$150 per		15% up to \$150 per script after	Pharmacy
	Current feelikh fee (a.e. ACC)				deductible
Outpatient	Surgery facility fee (e.g., ASC)				
services	Physician/surgeon fees				
	Outpatient visit				
	Emergency room facility fee (waived if admitted)			\$150	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	Integrated Family deductable NA			
	Urgent care	\$5		N/A N/A \$1,400 / \$100 / \$2,800 / \$200 / \$2,700 \$5,400 N/A N/A N/A Member Cost Share \$15 \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45 \$150 No charge \$15% \$15% \$15% \$15% \$15% \$15% \$15% \$15%	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee		X		Х
Mental		1070		1070	
health, behavioral health, or	visits	\$5		\$15	
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	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%	X	15%	×
health needs	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				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics	JU /0		3070	
	Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	50%		50%	

Common Medical	Service Type	Member Cost Share	Deductible
	HSA family plan: Individual deductible	N/A	
	HSA plan: Self-only coverage deductible	N/A	
	Family Out-of-pocket maximum	\$13,100 <u>\$13,000</u>	
	Individual Out-of-pocket maximum	\$6,550 <u>\$6,500</u>	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$550 / \$0	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,700 / \$275 / \$0	
	Integrated Family deductible	N/A	
	Integrated Individual deductible	N/A	
	Plan design includes a deductible?	Yes, Medical/Pharma	су
ctuarial Value - A	AV Calculator	73.8 <u>73.9</u> %	
lember Cost Share	e amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
ullillary of be	enefits and Coverage	au =	

	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$35		
Health care provider's	Other practitioner office visit	\$35		
office or clinic visit	Specialist visit	\$75		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$40		
Tests	X-rays and Diagnostic Imaging	\$85		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$16	Pharmac	
B	Tier 2	¢EE	Pharmac	
Drugs to treat illness	Hel 2	\$55	deductible	
or condition	Tier 3	\$85	Pharmac deductibl	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductible	
	Surgery facility fee (e.g., ASC)	20%		
Outpatient services	Physician/surgeon fees	20%		
	Outpatient visit	20%		
	Emergency room facility fee (waived if admitted)	\$400		
Need	Emergency room physician fee (waived if admitted)	No charge		
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		
	Urgent care	\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х	
Hospital stay	Physician/surgeon fee	20%		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		
nealth, 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 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			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray	No charge		
and Preventive	Sealants per Tooth	. to onargo		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	20%		
Services	Periodontal Maintenance Services			
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	50%		
	Prosthodontics			
Child	Oral Surgery			
Orthodontics	Medically necessary orthodontics	50%		

10.0 EHB Date: March 14, 2019May 16, 2019

Date: March 14, 2019 May 16, 2019		
Summary of Benefits and Coverage		
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	61.3<u>61.4</u>%	62.0 <u>62.1</u> %
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	\$6,950 <u>\$6,900</u> integrated
Integrated Comits deductible	NI/A	\$12,000\$12,900 intograted

Plan design includes a deductible?

Integrated Individual deductible
Integrated Family deductible
Individual deductible
Individual deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: Medical / Pharmacy / Dental
Family deductible, NOT integrated: \$6,300 / \$500 / \$0

N/A

S6,950\$Gee endnote
Family Out-of-pocket maximum
\$15,7850\$7,800
\$13,900\$See endnote
HSA plan: Self-only coverage deductible
N/A
\$6,950\$6,900

S6,950\$6,900

	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			\$ 6,95 0 <u>\$6,900</u> \$ 6,95 0 <u>\$6,900</u>	
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	\$65	After 1st three non- preventive visits	0%	Х
Health care provider's office or	Other practitioner office visit	\$65	After 1st three non- preventive visits	0%	x
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge	P . 0. 0. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	No charge	
	Laboratory Tests	\$40		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
	Tier 1	\$18	Pharmacy Deductible	0%	Х
Drugs to	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
treat illness or condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient services	Physician/surgeon fees	40%	×	0%	X
services	Outpatient visit	40%	×	0%	×
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
Need	Emergency room physician fee (waived if admitted)	No charge		0%	×
immediate attention	Medical transportation (including emergency and non-emergency)	40%	×	0%	×
	Urgent care	\$65	After 1st three non-	0%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		preventive visits		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	40% 40%	X X	0%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	X	0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	х	0%	х
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	X
recovering or other special	Skilled nursing care	40%	X	0%	x
health needs	Durable medical equipment	40%	×	0%	×
	Hospice service	No charge		0%	×
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	-		-	
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
A.	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

libel Cost Share	amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan
uarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$8,200 <u>\$8</u>	3,150 integrated
	Integrated Family deductible	\$16,400 <u>\$1</u>	6,300 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum		2 00 \$8,150
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$ 10,2	100 <u>\$16,300</u> N/A
	HSA family plan: Individual deductible		N/A
Common		Marshar Cast	
Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three n
dealth care provider's	Other practitioner office visit	0%	After 1st three n
office or	Specialist visit	00/	preventive visi
illic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
ests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
Orugs to	Tier 2	0%	X
reat illness	Tier 3	0%	×
or condition	riei 3	0%	X
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
Need	Emergency room physician fee (waived if admitted)	No charge	
mmediate attention	Medical transportation (including emergency and non-emergency)	0%	X
	Urgent care	0%	After 1st three r
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		preventive visi
Hospital stay	delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	X
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three n
ehavioral nealth, or	Volle		preventive visi
substance	Mental/behavioral health and substance use disorder other outpatient items and services	0%	X
	Prenatal care and preconception visits	No obargo	
Pregnancy	Home health care (cost share per visit)	No charge 0%	X
lelp ecovering or	Outpatient Rehabilitation and Habilitation services	0%	X
other special	Skilled nursing care	0%	X
leaith fieeus	Durable medical equipment	0%	X
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
Shild Dontol	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
nd Preventive	Sealants per Tooth	140 onlinge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	0%	X
Basic Bervices	Periodontal Maintenance Services	0%	*
	Crowns and Casts		
Child Dental	Endodontics		
/lajor	Periodontics (other than maintenance)	0%	X
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	0%	

9.5 EHB





	ents and Coverage imounts describe the Enrollee's out of pocket costs.	Platinum		Platinum	
Actuarial Value - AV		Coinsurance 91.7%	Plan	Copay Pla 89.1%	n
Actuariai value - Av					
	Plan design includes a deductible?	No \$0		No \$0	
	Integrated Individual deductible Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	Ω
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0/\$0/\$	
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or					
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15		\$15	
illness or	Tivo				
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services		10%		10%	
	Outpatient visit				
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need immediate	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 delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%		No charge	
Marcal de la la calida	Mental/behavioral health and substance use disorder outpatient office				
Mental health, behavioral	visits	\$15		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0.4.5		0.4.5	
abuse needs	items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in liquid glasses)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	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	Not Covered		Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
ctuarial Value - A	V Calculator	81.9 81.8%)	78.3%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$7,850 <u>\$7,8</u> 6		\$7,850 <u>\$7,8</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$15,700 <u>\$15,6</u> N/A	<u>500</u>	\$15,700 <u>\$15,</u> N/A	<u>600</u>
	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	\$30		\$30	
Health care provider's office or	Other practitioner office visit	\$30		\$30	
clinic visit	Specialist visit	\$60 <u>\$65</u>		\$60 <u>\$65</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$300	
services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
Need immediate	Emergency room facility fee (waived if admitted)	\$350		\$350	
	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	
Hospital stay	Physician/surgeon fee	20%		No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$30		\$30	
substance abuse 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	
Help	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
recovering or	Skilled nursing care	20%		\$300 per day up to	
other special health needs	Durable medical equipment	20%		5 days 20%	
	Hospice service			No charge	
	Figure 1	No charge		, and the second	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	140 Glaige		140 Glaige	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	·				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics	No.		No. 2	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

Summary of Benefits and Coverage		CCSB-only Gold		CCSB-only Gold	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan	n	Copay Plan	
Actuarial Value - A\		78.1%		79.6 <u>79.7</u> %	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharmacy N/A		Yes, Medical/Pharr	nacy
	Integrated Family deductible		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$250 / \$0 / \$0		N/A \$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$500 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$ 7,850 <u>\$7,800</u>		\$ 7, 850 <u>\$7,800</u>	
	Family Out-of-pocket maximum	\$15,700 <u>\$15,600</u>		\$15,700 <u>\$15,60</u>	0
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		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	\$25		\$25	
Health care					
provider's office or	Other practitioner office visit	\$25		\$25	
clinic visit	Specialist visit	\$50		\$50	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$25	
Tests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$50	
condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per 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)	\$250	X	\$250	х
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	x
	Urgent care	\$25		\$25	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X	\$600 per day up to 5 days	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X	No charge	,
Mental health,	Mental/behavioral health and substance use disorder outpatient office				
behavioral health, or	visits	\$25		\$25	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$25	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$30		\$30	
	Outpatient Rehabilitation and Habilitation services	\$25		\$25	
Help recovering or			· ·		
other special health needs	Skilled nursing care	20%	X	\$300 per day up to 5 days	X
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics Deliver the Control of				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child	Oral Surgery	Net O		Net O	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

ounniury or bon	efits and Coverage		
Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	r Plan
Actuarial Value - AV	/ Calculator	71.7 <u>71.8</u> %	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	n
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$600 /	
	Individual Out-of-pocket maximum	\$ 7,850 \$7,800	
	Family Out-of-pocket maximum	\$15,700 \$15,600	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit	\$40	
office or clinic visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmacy
Drugs to treat	Tier 2	\$60	deductible
illness or condition	Tier 3		deductible Pharmacy
Condition		\$90 20% up to \$250 per script	deductible Pharmacy
	Tier 4	after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$40	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
HOSPILAI SLAY	Physician/surgeon fee	20%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
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 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 Preventive	Sealants per Tooth	Not Covered	
i i dveillive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
Gervices	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

9.5 EHB

Summary of Ber	4, 2019 May 16, 2019 nefits and Coverage	CCSB-only Silver		CCSB-only Silver	
	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan		Copay Plan	
Actuarial Value - A\		70.5%		70.2%	
	Plan design includes a deductible?	Yes, Medical/Pharma	су	Yes, Medical/Pharm	acy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$	
	Individual Out-of-pocket maximum			\$ 7,850 \$7,800	
	Family Out-of-pocket maximum	\$15,700 <u>\$15,600</u>		\$15,700 <u>\$15,600</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	\$50		\$50	
Health care provider's	Other practitioner office visit	\$50		\$50	
office or		·			
clinic visit	Specialist visit	\$85		\$85	
	Preventive care/ screening/ immunization	No charge		No charge	
Territor	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$85		\$85	
	Imaging (CT/PET scans, MRIs)	20%	Dharre	\$300	Dhorma
	Tier 1	\$17	Pharmacy deductible	\$17	Pharmacy deductible
Drugs to treat	Tier 2	\$65	Pharmacy	\$65	Pharmacy
illness or	Tue		deductible Pharmacy		deductible Pharmacy
condition	Tier 3	\$90	deductible	\$90	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
	Surgery facility fee (e.g., ASC)	20%		20%	
Outpatient	Physician/surgeon fees	20%		20%	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$400	X	\$400	Х
Need	Emergency room physician fee (waived if admitted)	No charge	Α	No charge	^
immediate	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	X
attention		·	^		^
	Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$50		\$50	
Hospital stay	delivery, mental health, and substance use)	20%	X	20%	X
	Physician/surgeon fee	20%	X	20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$50		\$50	
behavioral health, or	visits	, , ,			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient	\$50		\$50	
	items and services				
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$50	
recovering or other special	Skilled nursing care	20%	X	20%	Х
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 Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
Services	Crowns and Casts				
Child Dental	Endodontics Derivedontics (other than maintenance)	Net Or and		Ni-t O	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Date: March 1	4 , 2019 <u>May 16, 2019</u>		
-	efits and Coverage	CCSB-o Silver	•
Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	HDHP P	
Actuarial Value - A\	/ Calculator	71.3%)
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$2,500 integ	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 integ	grated
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$6,850)
	Family Out-of-pocket maximum	\$13,70	0
	HSA plan: Self-only coverage deductible	\$2,500)
	HSA family plan: Individual deductible	See endr	note
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	20%	X
Health care provider's	Other practitioner office visit	20%	X
office or clinic visit	Coordinate visit	200/	V
Cillic visit	Specialist visit	20%	X
	Preventive care/ screening/ immunization Laboratory Tests	No charge 20%	X
Tests	X-rays and Diagnostic Imaging	20%	X
10010	Imaging (CT/PET scans, MRIs)	20%	X
		20% up to \$250 per	
	Tier 1	script	X
Drugs to treat	Tier 2	20% up to \$250 per script	X
illness or condition	Tier 3	20% up to \$250 per	X
		script 20% up to \$250 per	
	Tier 4	script	X
	Surgery facility fee (e.g., ASC)	20%	X
Outpatient services	Physician/surgeon fees	20%	X
	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	Х
Need	Emergency room physician fee (waived if admitted)	0%	X
immediate attention	Medical transportation (including emergency and non-emergency)	20%	X
	Urgent care	20%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X
		2070	Α
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	items and services	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	Х
Help	Outpatient Rehabilitation and Habilitation services	20%	X
recovering or other special	Skilled nursing care	20%	X
health needs	Durable medical equipment	20%	X
	Hospice service	0%	X
Child eye	Eye exam	No charge	
care	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		
Child Dental	Space Maintainers - Fixed Restorative Procedures		
Basic		Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
Child	Oral Surgery		
Orthodontics	Medically necessary orthodontics	Not Covered	

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL		
tuarial Value - A\	/ Calculator	94.5%		87.7%		
	Plan design includes a deductible?	Yes, Medical/Pharmacy		Yes, Medical/Pharmacy		
	Integrated Individual deductible	N/A		N/A		
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$1,400 / \$100 / \$0)	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$2,800 / \$200 / \$0		
	Individual Out-of-pocket maximum	\$1,000		\$2,700		
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$2,000 N/A	J	\$5,400 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	Other prestitioner office visit	0.5		045		
provider's office or	Other practitioner office visit	\$5		\$15		
clinic visit	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$8		\$20		
Tests	X-rays and Diagnostic Imaging	\$8		\$40		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
	Tier 1	\$3		\$5		
Orugs to treat	Tier 2	\$10		\$25	Pharmad deductib	
Ilness or condition	Tier 3	\$15		\$45	Pharma	
					deductib	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmad deductib	
	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		\$150		
Need	Emergency room physician fee (waived if admitted)	No charge		No charge		
mmediate attention	Medical transportation (including emergency and non-emergency)	\$30		\$75		
	Urgent care	\$5		\$15		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	X	15%	Х	
lospital stay	delivery, mental health, and substance use)		^		٨	
	Physician/surgeon fee	10%		15%		
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15		
substance buse 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		
lelp	Outpatient Rehabilitation and Habilitation services	\$5		\$15		
ecovering or other special	Skilled nursing care	10%	X	15%	Х	
nealth needs	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	NO charge		ino charge		
	Preventive - Cleaning					
Child Dental	•					
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered		
Preventive	Sealants per Tooth					
	Topical Fluoride Application					
Obild Day 1	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
DOI VICES	Prosthodontics					
	Oral Surgery					

9.5 EHB

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan	
tuarial Value - A\	·	200%-250% FPL 73.873.9 %	-
luariai value - A			201
	Plan design includes a deductible?	Yes, Medical/Pharm	iacy
	Integrated Individual deductible Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 / \$275 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$550 / \$	
	Individual Out-of-pocket maximum	\$ 6,550 \$6,500	
	Family Out-of-pocket maximum	\$13,100 <u>\$13,000</u>	ı
	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	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$75	
	'		
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$40	
Tests	X-rays and Diagnostic Imaging	\$ 4 0 \$85	
. 55.5	Imaging (CT/PET scans, MRIs)		
		\$325	Dharma
	Tier 1	\$16	Pharma deductib
Drugs to treat	Tier 2	\$55	Pharma
illness or			deductib Pharma
condition	Tier 3	\$85	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
301 11000	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate		_	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
noopital otay	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	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or			
other special health needs	Skilled nursing care	20%	X
	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		
01.11.12	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		

9.5 EHB Date: March 14, 2019 May 16, 2019

ember Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	
ctuarial Value - AV	/ Calculator	61.3<u>6</u>1.4 %		62.062.1	
otaariai valae 71v	Plan design includes a deductible?	Yes, Medical/Pharr	macv	Yes, integra	
	Integrated Individual deductible	N/A		\$6,950 <u>\$6,900</u> in	
	Integrated Family deductible	N/A		\$13,900 <u>\$13,800</u>	integrated
	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	\$ 7,850 \$ <u>7,800</u>		\$ 6,950 See er	<u>ndnote</u>
	Family Out-of-pocket maximum	\$15,700 <u>\$15,60</u>	<u>0</u>	\$13,900 <u>See e</u>	ndnote
	HSA plan: Self-only coverage deductible	N/A		\$6,950 <u>\$6,9</u>	
	HSA family plan: Individual deductible	N/A		\$6,950 <u>\$6,</u> 9	<u>900</u>
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	X
Health care	Other practitioner office visit	\$65	After 1st three non-	0%	X
provider's office or	Carlot practitioner critical viola	φοσ	preventive visits	0 70	_ ^
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	Х
	Imaging (CT/PET scans, MRIs)	40%	X	0%	Х
	Tier 1	\$18	Pharmacy Deductible	0%	х
Drugs to treat	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X
illness or		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy		
condition	Tier 3	pharmacy deductible	Deductible	0%	Х
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient	Physician/surgeon fees	40%	×	0%	X
services	Outpatient visit	40%	×	0%	X
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
Need	Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted)		_ ^		
immediate		No charge		0%	X
attention	Medical transportation (including emergency and non-emergency)	40%	X After 1st three non-	0%	X
	Urgent care	\$65	preventive visits	0%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	Х	0%	Х
pi otay	Physician/surgeon fee	40%	Х	0%	х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	Х
health, or substance	Mental/behavioral health and substance use disorder other outpatient		·		
abuse needs	items and services	\$65	X	0%	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	X	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	Х
recovering or other special	Skilled nursing care	40%	×	0%	Х
health needs	Durable medical equipment	40%	×	0%	X
	Hospice service	No charge		0%	Х
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				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
50.11003	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	,	IAOL COACIGO		NOT COVERE	
	Prosthodontics Oral Surgery				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

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Summary of	Ranafite	and Cov	/Arana

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Catastrophic Plan				
Actuarial Value - A	amounts describe the Enrollee's out of pocket costs.	Catas	ropnic Plan	
Actuariai value - A	Plan design includes a deductible?	Yes.	integrated	
	Integrated Individual deductible		,150 integrated	
	Integrated Family deductible	\$16,400 <u>\$1</u>	6,300 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
	Individual Out-of-pocket maximum		200 <u>\$8,150</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$16, 4	100 <u>\$16,300</u> N/A	
	HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits	
Health care provider's office or	Other practitioner office visit	0%	After 1st three non- preventive visits	
clinic visit	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	0%	X	
Tests	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
	Tier 1	0%	Х	
Drugs to treat	Tier 2	0%	X	
illness or condition	Tier 3	0%	X	
	Tier 4	0%	Х	
	Surgery facility fee (e.g., ASC)	0%	X	
Outpatient	Physician/surgeon fees	0%	×	
services	Outpatient visit	0%	×	
	Emergency room facility fee (waived if admitted)	0%	X	
Need	Emergency room physician fee (waived if admitted)	No charge		
immediate attention	Medical transportation (including emergency and non-emergency)	0%	x	
	Urgent care	0%	After 1st three non-	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	preventive visits	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	X	
Mental health.	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-	
behavioral health, or	visits	0%	preventive visits	
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		
0)	Home health care (cost share per visit)	0%	×	
	Outpatient Rehabilitation and Habilitation services	0%	X	
Help recovering or		0%	X	
other special health needs	Skilled nursing care			
	Durable medical equipment	0%	X	
	Hospice service	0%	Х	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	X	
	Oral Exam	0 70	^	
	Preventive - Cleaning			
Child Dental	Preventive - X-ray			
Diagnostic and	Sealants per Tooth	Not Covered		
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Services	Not Covered		
3.1.300	Crowns and Casts			
	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics	55.0100		
	Oral Surgery			
Child	Medically necessary orthodontics	Not Covered		
Orthodontics	modically necessary orthodorines	not covered		

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

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

Tier	Definition
1	Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
2	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

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.
- 31) The Bronze HDHP is contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2020 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.