Covered California 2020 2021 Patient-Centered Benefit Plan Designs¹

Final Board-approved Proposed May 16, 2019 March 26, 2020

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

10.0 EHB

Date: May 16, 2019 March 26, 2020

Summary of Benefits and Coverage



ctuarial Value - A	amounts describe the Enrollee's out of pocket costs.	Coinsurance 91.791.69		Copay Pla 89.189.39	
otaunar value - A	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 / \$	50 / \$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	Deductil Applie
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic	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	
Ilness 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	
services	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	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	A 4=		_	
behavioral	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	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health 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			90	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	200/		See 2020 2021	
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
	Desired anti-resolution (attack and the second	50%		See 2020 2021 Dental Copay	
Child Dental Major	Periodontics (other than maintenance)				
	Periodontics (other than maintenance) Prosthodontics			Schedule	
Major	Prosthodontics Oral Surgery				

20202021 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 16, 2019 March 26, 2020

	, 2019 <u>March 26, 2020</u>				
-	nefits and Coverage	CCSB-onl Platinum		CCSB-onl Platinum	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	
Actuarial Value - A	V Calculator	91.7% 90.5	<u>%</u>	89.1% <u>88.3</u>	<u>%</u>
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0	0	\$0	0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$		\$0/\$0/\$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$0 / \$0 / \$ \$4,500	U	\$0 / \$0 / \$ \$4,500	U
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common	A	Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15 <u>\$20</u>	
Health care	Other practitioner office visit	\$15		\$15 \$20	
provider's office or clinic	Other practitioner office visit	φισ		\$13 \$20	
visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15 <u>\$20</u>	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75 <u>\$100</u>	
	Tier 1	\$5 <u>\$10</u>		\$5	
Drives to to t	Tier 2	\$15 <u>\$25</u>		\$15 <u>\$20</u>	
Drugs to treat illness or					
condition	Tier 3	\$25 <u>\$40</u>		\$25 <u>\$30</u>	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	0 () () () () ()	script		script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150 <u>\$200</u>		\$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 <u>\$20</u>	
	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	
Mental health.	Mental/behavioral health and substance use disorder outpatient office				
behavioral	visits	\$15		\$15 <u>\$20</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$15		\$15 <u>\$20</u>	
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 \$20	
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	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		_	
	Oral Exam	140 Charge		No charge	
Child Dental	Preventive - Cleaning Preventive - X-ray				
Diagnostic and	•	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed			Soc 20000004	
Child Dental Basic Services	Restorative Procedures	20%		See 2020 2021 Dental Copay	
Dasic Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2020 2021	
Major Services	Periodontics (other than maintenance)	50%		Dental Copay Schedule	
00111003	Prosthodontics			Sorioudio	
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

10.0 EHB

Date: May 16, 2019 March 26, 2020			
Summary of Benefits and Coverage			
Member Cost Share amounts describe the Enrollee's out of p	pocket costs.	Individual-only Gold Coinsurance Plan	Individual-only Gold Copay Plan
Actuarial Value - AV Calculator		81.8% <u>81.9%</u>	78.3% <u>78.0%</u>
	Plan design includes a deductible?	No	No
	Integrated Individual deductible	\$0	\$0
	Integrated Family deductible	\$0	\$0

\$0 / \$0 / \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum \$7,800\$8,200 \$7,800<u>\$8,200</u> Family Out-of-pocket maximum \$15,600<u>\$16,400</u> \$15,600<u>\$16,400</u> HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Member Cost Share Common Medical Event Member Cost Deductible Applies Deductible Applies Service Type Share Primary care visit to treat an injury, illness, or condition \$30\$35 \$30<u>\$35</u> Health care provider's office or clinic visit Other practitioner office visit \$30\$35 \$30\$35 Specialist visit \$65 \$65 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$40 \$40 X-rays and Diagnostic Imaging \$75 \$75 Tests Imaging (CT/PET scans, MRIs) \$275<u>\$150</u> 20%

	Tier 1	\$15	\$15
Drugs to treat	Tier 2	\$55	\$55
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
Outpatient services	Physician/surgeon fees	20%	\$40
	Outpatient visit	20%	20%
	Emergency room facility fee (waived if admitted)	\$350	\$350
Need	Emergency room physician fee (waived if admitted)	No charge	No charge
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	\$250
	Urgent care	\$30 <u>\$35</u>	\$30 <u>\$35</u>
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	\$600 per day up to 5 days
,,	Physician/surgeon fee	20%	No charge
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$30 <u>\$35</u>	\$30 <u>\$35</u>
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30 <u>\$35</u>	\$30 <u>\$35</u>
Pregnancy	Prenatal care and preconception visits	No charge	No charge
	Home health care (cost share per visit)	20%	\$30
Help	Outpatient Rehabilitation and Habilitation services	\$30 \$35	\$30 <u>\$35</u>
recovering or other special	Skilled nursing care	20%	\$300 per day up to 5 days
health needs	Durable medical equipment	20%	20%
	Hospice service	No charge	No charge
Child are same	Eye exam	No charge	No charge
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	No charge
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No alcono	No alcoura
and Preventive	Sealants per Tooth	No charge	No charge
1.040111140	Topical Fluoride Application		
	Snace Maintainers - Fixed		

	items and services		
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 \$35	\$30 <u>\$35</u>
recovering or other special	Skilled nursing care	20%	\$300 per day up to 5 days
health needs	Durable medical equipment	20%	20%
	Hospice service	No charge	No charge
Child eye care	Eye exam	No charge	No charge
Cillia eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	No charge
	Oral Exam		
Child Dantal	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	No charge
and Preventive	Sealants per Tooth	140 Glaige	No charge
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	20%	See 2020 2021 Dental Copay
Basic Services	Periodontal Maintenance Services	2070	Schedule
	Crowns and Casts		
Child Dental	Endodontics		See 2020 2021
Major Services	Periodontics (other than maintenance)	50%	Dental Copay
Services	Prosthodontics		Schedule
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	\$1,000

Medically necessary orthodontics

10.0 EHB Date: May 16, 2019 March 26, 2020 CCSB-only Summary of Benefits and Coverage CCSB-only Member Cost Share amounts describe the Enrollee's out of pocket costs Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 78.1%78.2% Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy Integrated Individual deductible N/A N/A Integrated Family deductible N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$250\$350 / \$0 / \$0 \$250 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$500<u>\$700</u> / \$0 / \$0 \$500 / \$0 / \$0 Individual Out-of-pocket maximum \$7,800 \$7,800 \$15,600 \$15,600 Family Out-of-pocket maximum HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Deductible Service Type Member Cost Share Member Cost Share Medical Event Primary care visit to treat an injury, illness, or condition \$25 \$25\$35 Health care Other practitioner office visit \$25 \$25\$35 provider's office or clinic Specialist visit \$50 \$50\$55 visit Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$25 \$25\$35 Tests X-rays and Diagnostic Imaging \$65 \$65\$55 Imaging (CT/PET scans, MRIs) 20% \$275\$250 Tier 1 \$15 \$15 Tier 2 \$50 \$50\$40 Drugs to treat illness or condition Tier 3 \$80 \$80\$70 Tier 4 20% up to \$250 per script 20% up to \$250 per script Surgery facility fee (e.g., ASC) 20% \$300 Х Outpatient Physician/surgeon fees 20% \$40\$35 Outpatient visit 20% 20% Emergency room facility fee (waived if admitted) \$250 \$25020% Need Emergency room physician fee (waived if admitted) No charge No charge immediate Medical transportation (including emergency and non-emergency) \$25020% \$250 attention Urgent care \$25 \$25\$35 Facility fee (e.g. hospital room) for inpatient stay (including labor and 20% \$600 per day up to 5 days delivery, mental health, and substance use) Hospital stay Physician/surgeon fee 20% No charge Mental/behavioral health and substance use disorder outpatient office Mental health, \$25 \$25\$35 visits health, or substance abuse needs Mental/behavioral health and substance use disorder other outpatient \$25 \$25\$35 items and services Pregnancy Prenatal care and preconception visits No charge No charge Home health care (cost share per visit) \$3020% \$30 Outpatient Rehabilitation and Habilitation services \$25 Help recovering or Skilled nursing care 20% Х \$300 per day up to 5 days Х other special health needs Durable medical equipment 20% 20% Hospice service No charge No charge Eye exam No charge No charge Child eve 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 No charge No charge and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures See <u>20202021</u> Dental Copay Schedule Child Dental 20% Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental See 20202021 Dental Copay Major Services Periodontics (other than maintenance) 50% Schedule Prosthodontics Oral Surgery

\$1,000

50%

Summary	of Ranafi	te and Co	overage

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
Actuarial Value - A	V Calculator	71.8% <u>70.8%</u>	
	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	\$7,800 <u>\$8,200</u>	
	Family Out-of-pocket maximum	\$15,600 <u>\$16,400</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Modical Event	Primary care visit to treat an injury, illness, or condition	\$40	7.100
Health care	Other practitioner office visit	\$40	
provider's office or clinic		Ψ+ο	
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 deductible
	Tier 2	\$60	Pharmacy
Drugs to treat illness or	110. 2	φυυ	deductible
condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
00111000	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	
attontion	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	20%	X
	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	Skilled nursing care	20%	X
other special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	110 Glarge	
	Preventive - Cleaning		
Child Dental	· ·		
Diagnostic and	Preventive - X-ray Seplants per Teeth	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	20%	
200.3 00. 11003	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

_	, 2019<u>March 26, 2020</u> 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	N Calculator	70.5% 71.6%		70.2% <u>70.9%</u>	
	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	\$7,800<u>\$8,200</u>		\$ 7,800 \$ <u>8,200</u>	
	Family Out-of-pocket maximum	\$15,600 <u>\$16,400</u>		\$15,600 <u>\$16,400</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
	TIGA family plan. Individual deductible	IVA		INA	
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 <u>\$55</u>	
Health care provider's	Other practitioner office visit	\$50		\$50 \$55	
office or clinic visit	Specialist visit	\$85		\$ 85 \$90	
VISIL	•			_	
	Preventive care/ screening/ immunization	No charge		No charge	
Teets	Laboratory Tests	\$40 <u>\$50</u>		\$40 <u>\$55</u>	
Tests	X-rays and Diagnostic Imaging	\$85		\$85 <u>\$90</u>	
	Imaging (CT/PET scans, MRIs)	20% 30%	X	\$300	X
	Tier 1	\$17	Pharmacy deductible	\$17	Pharmacy deductible
Description 1	Tier 2	\$65 \$7 <u>0</u>	Pharmacy	\$ 65 \$80	Pharmacy
Drugs to treat illness or	1012	φοο <u>φτο</u>	deductible Pharmacy	φοο <u>φου</u>	deductible Pharmacy
condition	Tier 3	\$90 <u>\$100</u>	deductible	\$90 \$110	deductible
	Tier 4	20%30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20%30% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20% 30%	<u>X</u>	20% 30%	X
Outpatient	Physician/surgeon fees	20%30%	Δ	20%30%	<u>~</u>
services					
	Outpatient visit	20% 30%	.,	20% 30%	.,
	Emergency room facility fee (waived if admitted)	\$400 <u>30%</u>	X	\$400 <u>30%</u>	Х
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$ 250 30%	X	\$ 250 30%	X
	Urgent care	\$50		\$50 <u>\$55</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20% 30%	X	20% 30%	X
Hospital stay	Physician/surgeon fee	20% 30%	X	20% 30%	
Mental health.	Mental/behavioral health and substance use disorder outpatient office	_			
behavioral	visits	\$50		\$ 50 \$ <u>55</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$50		\$50 <u>\$55</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20% 30%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$50 <u>\$55</u>	
recovering or	Skilled nursing care	20%30%	X	20% 30%	X
other special health needs	Durable medical equipment	20% 30%		20% 30%	
	Hospice service	No charge		No charge	
	Eye exam			No charge	
Child eye care		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	20%		See 20202021 Dental Copay	
Basic Services	Periodontal Maintenance Services	20 /0		Schedule	
	Crowns and Casts				
Objects	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 20202021 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	• •	50%		\$1,000	
Orthodontics	Medically necessary orthodontics	JU%		\$1,000	

Child

Medically necessary orthodontics

50%

10.0 EHB Date: May 16, 2019 March 26, 2020 CCSB-only Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. **HDHP Plan** Actuarial Value - AV Calculator 71.3%71.8% Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2,500 integrated Integrated Family deductible \$5,000 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A Individual Out-of-pocket maximum \$6,850 \$13,700 Family Out-of-pocket maximum HSA plan: Self-only coverage deductible \$2.500 HSA family plan: Individual deductible See endnote Common Service Type Member Cost Share Deductible Applie Medical Event Primary care visit to treat an injury, illness, or condition 20% Х Health care Other practitioner office visit 20% Χ provider's office or clinic Specialist visit 20% visit Preventive care/ screening/ immunization No charge Laboratory Tests 20% Х X-rays and Diagnostic Imaging 20% Tests Х Imaging (CT/PET scans, MRIs) 20% Х 20% up to \$250 per Tier 1 Х 20% up to \$250 per Tier 2 Х Drugs to treat script illness or 20% up to \$250 per condition Tier 3 Х 20% up to \$250 per Tier 4 Х Surgery facility fee (e.g., ASC) 20% Х Outpatient Physician/surgeon fees 20% Х Outpatient visit 20% Х Emergency room facility fee (waived if admitted) 20% Х Emergency room physician fee (waived if admitted) 0% immediate Medical transportation (including emergency and non-emergency) 20% Х attention Urgent care 20% X 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/behavioral health and substance use disorder outpatient office Mental health, 20% Х behavioral health, or substance abuse needs Mental/behavioral health and substance use disorder other outpatient 20% items and services Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) 20% Х Outpatient Rehabilitation and Habilitation services 20% Help recovering or Skilled nursing care 20% Х other special health needs Durable medical equipment 20% Hospice service 0% Х Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning **Child Dental** Preventive - X-ray Diagnostic No charge and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures **Child Dental** 20% **Basic Services** Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Major Services Periodontics (other than maintenance) 50% Prosthodontics Oral Surgery

Summary of	f Benefits	and Cov	erage

	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPL	
Actuarial Value - A	V Calculator	94.5 % <u>94</u>		87.7% <u>87.9%</u>	
	Plan design includes a deductible?	Yes, Medical/F	harmacy	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		\$1,400 / \$100 / \$6	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$2,800 / \$200 / \$6)
	Individual Out-of-pocket maximum			\$ 2,700 \$2,850 \$ 5,400 \$5,700	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		J	\$5,400 <u>\$5,700</u> N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$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		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
illness or condition	Tier 3	\$15		\$45	Pharmacy
Condition					deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible
0.1	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	
immediate 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%	Х	15%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		15%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office				
behavioral	visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient	\$5		\$15	
Pregnancy	renatal care and preconception visits	No charge		No charge	
riegilalicy		_		-	
	Home health care (cost share per visit)	\$3		\$15	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
other special	Skilled nursing care	10%	X	15%	X
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
a oyo 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	No. 1		N	
and Preventive	Sealants per Tooth	No charge		No charge	
reventive	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			5575	
	Oral Surgery				
Child	• •	E00/		F00/	
Orthodontics	Medically necessary orthodontics	50%		50%	

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
ctuarial Value - A	·	200%-250% FPL 73.9%73.6%	-
totaariai vaido 7	Plan design includes a deductible?	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	,
	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 / \$	0
	Individual Out-of-pocket maximum	\$6,500	
	Family Out-of-pocket maximum	\$13,000	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$75	
VISIL	Specialist visit		
	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 deductible
Drugs to treat	Tier 2	\$55	Pharmac deductibl
illness or condition	Tier 3	\$85	Pharmad deductibl
	Tier 4	20% up to \$250 per script	Pharmad
	Surgery facility fee (e.g., ASC)	after pharmacy deductible 20%	deductibl
Outpatient			
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	\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
oopu. o.u.	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	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
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	140 orlange	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental		E00/	
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

Summary	of Bene	efits and	l Coverage

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze		
Actuarial Value - AV Calculator		61.4% 64.9%		HDHP Plan 62.1%64.6%		
	Plan design includes a deductible?	Yes, Medical/Pharmacy		Yes, integra	ted	
	Integrated Individual deductible	N/A		\$6,900 <u>\$7,000</u> into	egrated	
	Integrated Family deductible	N/A		\$13,800 <u>\$14,000</u> integrated		
	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	\$ 7,800 \$ <u>8,200</u> \$ 15,600 \$ <u>16,40</u> 0		See endnot		
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$15,000<u>\$</u>10,400 N/A	2	\$6,900\$7,00		
	HSA family plan: Individual deductible	N/A		\$6,900 <u>\$7,0</u>		
Common	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible	
Medical Event	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non-	0%	Applies X	
Health care			preventive visits After 1st three non-			
provider's office or clinic	Other practitioner office visit	\$65	preventive visits	0%	Х	
visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	Х	
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$40		0%	Х	
Tests	X-rays and Diagnostic Imaging	40%	Х	0%	Х	
	Imaging (CT/PET scans, MRIs)	40%	Х	0%	Х	
	Tier 1	\$18	Pharmacy Deductible	0%	х	
Deuga ta turi	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X	
Drugs to treat illness or		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy			
condition	Tier 3	pharmacy deductible	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%	Х	
Outpatient services	Physician/surgeon fees	40%	X	0%	Х	
	Outpatient visit	40%	X	0%	Х	
	Emergency room facility fee (waived if admitted)	40%	X	0%	Х	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		0%	Х	
attention	Medical transportation (including emergency and non-emergency)	40%	X	0%	X	
	Urgent care	\$65	After 1st three non- preventive visits	0%	Х	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	Х	
Hospital stay	Physician/surgeon fee	40%	Х	0%	x	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	х	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient 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%	Х	0%	х	
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	х	
recovering or other special	Skilled nursing care	40%	X	0%	Х	
health needs	Durable medical equipment	40%	X	0%	X	
	Hospice service	No charge		0%	х	
	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
and	Sealants per Tooth	No charge		No charge		
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	20%		20%		
	Crowns and Casts					
01.11.15	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		50%		
Services	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	50%		50%		
Orthodontics	•					

Date: May 16, 2019 March 26, 2020

Summary of Benefits and Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catast	trophic Plan
Actuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$8,150 <u>\$8</u>	,550 integrated
	Integrated Family deductible	\$16,300 <u>\$1</u>	7,100 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A N/A
	Individual Out-of-pocket maximum		150\$8,550
	Family Out-of-pocket maximum	\$16,3	300 <u>\$17,100</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three non- preventive visits
office or clinic visit	Specialist visit	0%	×
	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%	X
Drugs to treat	Tier 2	0%	X
illness or condition	Tier 3	0%	X
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient	Physician/surgeon fees	0%	X
services	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
Need	Emergency room physician fee (waived if admitted)		^
immediate	Medical transportation (including emergency and non-emergency)	No charge	_
attention		0%	X After 1st three non-
	Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	preventive visits
Hospital stay	delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- 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	
	Home health care (cost share per visit)	0%	X
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	Х
	Hospice service	0%	Х
Child	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No -1	
and Preventive	Sealants per Tooth	No charge	
. Toventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	0%	Х
Basic Services	Periodontal Maintenance Services		
	Crowns and Casts Endodontics		
Child Dental Major		0%	X
Services	Periodontics (other than maintenance) Prosthodontics	U 70	^
	Prostrodontics Oral Surgery		
Child	Medically necessary orthodontics	0%	X
Orthodontics	,,	0,0	^

Date: May 16, 2019 March 26, 2020 Summary of Benefits and Coverage



lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only P Copay Pla	
ctuarial Value - A	V Calculator	91.7 91.69	<u>6</u>	89.1<u>89.3</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 / \$	
	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	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
	nsa family plan. Individual deductible	IV/A		IV/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	Specialist visit	\$30		\$30	
	•				
	Preventive care/ screening/ immunization	No charge		No charge	
Toete	Laboratory Tests X-rays and Diagnostic Imaging	\$15 \$30		\$15 \$30	
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	
liness or					
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	0 (100 (100)	script		script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
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	
mmediate 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)			5 days	
	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
behavioral health, or	visits				
substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services				
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		10%		5 days 10%	
	Durable medical equipment				
	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				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray	N		N. C	
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Restorative Procedures				
Child Dental Basic Services		Not Covered		Not Covered	
20.71003	Periodontal Maintenance Services				
	Crowns and Casts				
Child Deuts	Endodontics				
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	0.10				
	Oral Surgery				

	nefits and Coverage	CCSB-on		CCSB-onl	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinum Coinsurance Plan		Platinum Copay Plan	
Actuarial Value - A	V Calculator	91.7% <u>90.5%</u>		89.1% <u>88.3%</u>	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0	0	\$0	•
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$ \$0 / \$0 / \$		\$0/\$0/\$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$4,500	U	\$0 / \$0 / \$ \$4,500	U
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15 <u>\$20</u>	
provider's office or clinic	Other practitioner office visit	\$15		\$15 <u>\$20</u>	
visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15 <u>\$20</u>	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75 <u>\$100</u>	
	Tier 1	\$5 <u>\$10</u>		\$5	
Drugs to treat	Tier 2	\$15 <u>\$25</u>		\$15 <u>\$20</u>	
condition	Tier 3	\$25 <u>\$40</u>		\$25 <u>\$30</u>	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
0.1	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150 <u>\$200</u>		\$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 <u>\$20</u>	
	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	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15 \$20	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$15		\$15 <u>\$20</u>	
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 <u>\$20</u>	
recovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Ohit	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic and	Preventive - X-ray	No charge		Not Covered	
Preventive	Sealants per Tooth	140 charge		1401 COVEIEU	
	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 Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

	, 2019 March 26, 2020 nefits and Coverage				
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
Actuarial Value - A	V Calculator	81.8% <u>81.9</u> 9	<u>%</u>	78.3% 78.0	<u>%</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 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	· ·		\$7,800 <u>\$8,2</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		<u>400</u>	\$15,600 <u>\$16,</u> N/A	<u>400</u>
	HSA family plan: Individual deductible			N/A	
Common		Member Cost	D = d = 4ib.l =	Member Cost	Dadwatible
Medical Event	Service Type	Share	Deductible Applies	Share	Deductible Applies
Haalth assa	Primary care visit to treat an injury, illness, or condition	\$30 <u>\$35</u>		\$30 <u>\$35</u>	
Health care provider's office or clinic	Other practitioner office visit	\$30 <u>\$35</u>		\$30 \$35	
visit	Specialist visit	\$65		\$65	
	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 <u>\$150</u>	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
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	
Outpatient	Physician/surgeon fees	20%		\$40	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care				
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$30 <u>\$35</u>		\$30 <u>\$35</u> \$600 per day up to	
Hospital stay	delivery, mental health, and substance use)	20%		5 days	
	Physician/surgeon fee	20%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$30 <u>\$35</u>		\$30 <u>\$35</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$30 <u>\$35</u>		\$30 \$35	
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 <u>\$35</u>		\$30 <u>\$35</u>	
recovering or other special	Skilled nursing care	20%		\$300 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
Freventive	Topical Fluoride Application				
	Space Maintainers - Fixed Restorative Procedures				
Child Dental 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				
Ohitel	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

	, 2019March 26, 2020	CCSB-only		CCSP only		
Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Gold		CCSB-only Gold		
·		Coinsurance Plan		Copay Plan		
Actuarial Value - A		78.1% 78.2%		79.7% 79.4%		
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	Yes, Medical/Pharmacy		
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		0	\$250 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ <u>250</u> \$350 / \$0 / \$ \$ <u>500</u> \$700 / \$0 / \$		\$500 / \$0 / \$0		
	Individual Out-of-pocket maximum		-	\$7,800		
	Family Out-of-pocket maximum			\$15,600		
	HSA plan: Self-only coverage deductible	N/A		N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$25 \$35		
Health care	Other practitioner office visit	\$25		\$25 \$3 <u>5</u>		
provider's office or clinic	Other practitioner office visit	ΨΖΟ		φεο <u>φου</u>		
visit	Specialist visit	\$50		\$50 <u>\$55</u>		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$25 <u>\$35</u>		
Tests	X-rays and Diagnostic Imaging	\$65		\$65 <u>\$55</u>		
	Imaging (CT/PET scans, MRIs)	20%		\$275 <u>\$250</u>	X	
	Tier 1	\$15		\$15		
Drugs to treat	Tier 2	\$50		\$50 \$40		
illness or condition	Tier 3	\$80		<u>\$80</u> \$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300	<u>X</u>	
Outpatient services	Physician/surgeon fees	20%		\$40 <u>\$35</u>		
00.1.000	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	\$ 250 20%	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 20%	x	\$250	Х	
attention	Urgent care	\$25	,	\$25\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			_		
Hospital stay	delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	Х	
	Physician/surgeon fee	20%	X	No charge		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		<u>\$25\$35</u>		
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$25 <u>\$35</u>		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
Fregulaticy		No charge				
	Home health care (cost share per visit)	\$30 20%		\$30		
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$25 <u>\$35</u>		
recovering or 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		
Q1 III :	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered		
57511076	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures	Not Covered		Not Covered		
	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		
Orthodontics						

9.5 EHB

Date: May 16, 2019March 26, 2020 Summary of Benefits and Coverage

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
Actuarial Value - A	V Calculator	71.8% <u>70.8%</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 / \$ \$8,000 / \$600 / \$	
	Individual Out-of-pocket maximum	\$7,800 <u>\$8,200</u>	J
	Family Out-of-pocket maximum	\$15,600 \$16,400	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's office or clinic	Other practitioner office visit	\$40	
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 deductible
Drugs to treat	Tier 2	\$60	Pharmacy deductible
illness or condition	Tier 3	\$90	Pharmacy
		20% up to \$250 per script	deductible Pharmacy
	Tier 4	after pharmacy deductible	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 immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
Hospital stay	Physician/surgeon fee	20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$40	
behavioral health, or	visits		
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%	Х
other special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	9-	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and Preventive	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered	
, 5. 501 11003	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	
Jimouoniucs			

	, 2019<u>March 26, 2020</u> nefits and Coverage	CCSB-only		CCSB-only		
-	amounts describe the Enrollee's out of pocket costs.	Silver		Silver		
Actuarial Value - AV Calculator		Coinsurance Plar	1	Copay Plan		
Actuariai value - A		70.5% 71.6%		70.2% 70.9%		
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharma	acy	Yes, Medical/Pharmacy N/A		
	Integrated Family deductible	N/A		N/A N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0)	\$2,250 / \$300 / \$0	0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$6		
	Individual Out-of-pocket maximum			\$ 7,800 \$8,200		
	Family Out-of-pocket maximum			\$15,600 <u>\$16,400</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		\$ 5 0 <u>\$55</u>		
Health care	Other practitioner office visit	\$50		\$50 \$5 <u>5</u>		
provider's office or clinic	Other practitioner office visit	\$50		\$30 \$33		
visit	Specialist visit	\$85		\$85 <u>\$90</u>		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$40 <u>\$50</u>		\$40 <u>\$55</u>		
Tests	X-rays and Diagnostic Imaging	\$85		\$85 <u>\$90</u>		
	Imaging (CT/PET scans, MRIs)	20% 30%	X	\$300	X	
	Tier 1	\$17	Pharmacy deductible	\$17	Pharmacy deductible	
	Tier 2	#0F# 3 0	Pharmacy	#05#00	Pharmacy	
Drugs to treat illness or	Tier 2	\$65 <u>\$70</u>	deductible	\$65 <u>\$80</u>	deductible	
condition	Tier 3	\$ 90 \$100	Pharmacy deductible	\$ 9 0 <u>\$110</u>	Pharmacy deductible	
	Tier 4	20%30% up to \$250 per script	Pharmacy	20%30% up to \$250 per script	Pharmacy	
		after pharmacy deductible	deductible	after pharmacy deductible	deductible	
Outpatient	Surgery facility fee (e.g., ASC)	20% 30%	X	20% 30%	X	
services	Physician/surgeon fees	20% 30%		20% 30%		
	Outpatient visit	20% 30%		20% 30%		
	Emergency room facility fee (waived if admitted)	\$400 30%	X	\$400 30%	Χ	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge		
attention	Medical transportation (including emergency and non-emergency)	\$250 <u>30%</u>	Х	\$250 30%	X	
	Urgent care	\$50		\$50 <u>\$55</u>		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20% 30%	Х	20% 30%	X	
Hospital stay	delivery, mental health, and substance use)					
	Physician/surgeon fee	20% 30%	X	20% 30%		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$ 5 0 <u>\$55</u>		
health, or						
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$50 <u>\$55</u>		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20% 30%		\$45		
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$ <u>50\$55</u>		
recovering or	Skilled nursing care	20% 30%	x	20% 30%	X	
other special health needs	-					
	Durable medical equipment	20%30%		20% 30%		
	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					
	Preventive - Cleaning					
Child Dental Diagnostic and	Preventive - X-ray	Not Covered		Not Covered		
Preventive	Sealants per Tooth	Not Covered		Not Covered		
	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	N O		Net O		
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
major corvioco	5 " 1 "					
	Prosthodontics					
Child	Prosthodontics Oral Surgery					

20202021 Patient-Centered Benefit Plan Designs 9.5 EHB Date: May 16 2019March 26 2020

	2019March 26, 2020	0000	
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver	• *
Actuarial Value - A	V Calculator	HDHP P 71.3%71	
/ lotacinal value /	Plan design includes a deductible?		
	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	N/A	
	Individual Out-of-pocket maximum		
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		
	HSA family plan: Individual deductible		
Common			
Medical Event	Service Type	Member Cost Share	Deductible Applies
1110	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	Specialist visit	20%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	Х
Tests	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
	Tier 1	20% up to \$250 per	Х
		script 20% up to \$250 per	
Drugs to treat illness or	Tier 2	script	X
condition	Tier 3	20% up to \$250 per script	х
	Tier 4	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%	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%	X
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
oop.ia. otay	Physician/surgeon fee	20%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office	20%	X
behavioral health, or	visits	2070	^
substance	Mental/behavioral health and substance use disorder other outpatient	20%	X
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	X
Help	Outpatient Rehabilitation and Habilitation services	20%	Х
recovering or other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	х
	Hospice service	0%	Х
Child ove care	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray	Not Covered	
Diagnostic and Preventive	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered	
, , , , , , , , , , , , , , , , , , , ,	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	
2			

9.5 EHB

Date: May 16, 2019 March 26, 2020 Summary of Benefits and Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan	
Actuarial Value - AV Calculator		100%-150% FPL 94.5% 94.1%		150%-200% FPL 87.7%87.9%	
/ totalital value /	Plan design includes a deductible?			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		\$1,400 / \$100 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$150 / \$0 \$1,00		\$2,800 / \$200 / \$ \$ 2,700 \$2,850	U
	Family Out-of-pocket maximum			\$5,400 <u>\$5,700</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
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
provider's office or clinic	Other practitioner office visit	\$5		\$15	
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	
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
illness or condition	Tier 3	\$15		\$45	Pharmacy
	T. 4	10% up to \$150 per		15% up to \$150 per script	deductible Pharmacy
	Tier 4	script		after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	10%		15%	
services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
Need	Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted)	\$50		\$150	
immediate	Medical transportation (including emergency and non-emergency)	No charge \$30		No charge \$75	
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	X	15%	X
Hospital stay	delivery, mental health, and substance use)		^		^
	Physician/surgeon fee	10%		15%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	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%	X
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
,	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Day to	Restorative Procedures				
Child Dental Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
major our vices	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
2.3.000111103					

9.5 EHB

-	nefits and Coverage	Silver Plan	
	amounts describe the Enrollee's out of pocket costs.	200%-250% FPI	
Actuarial Value - A		73.9% 73.6%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm	iacy
	Integrated Figure 1 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 / \$	0
	Individual Out-of-pocket maximum	\$6,500	
	Family Out-of-pocket maximum	\$13,000	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$35	
provider's office or clinic	Other practitioner office visit	\$35	
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	Pharmacy deductible
Drugs to treat illness or	Tier 2	\$55	Pharmacy deductible
condition	Tier 3	\$85	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy 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	\$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 health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
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%	X
other special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	140 Glaige	
	Preventive - Cleaning		
Child Dental	· ·		
Diagnostic and	Preventive - X-ray Scalanta per Tooth	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	Not Covered	
Duoio Gervices	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child			

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze	
Actuarial Value - AV Calculator				HDHP Plan 62.1%64.6%	
Actuariai Value - A		61.4%64.9%		Yes, integrated	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharmacy N/A		\$6,900\$7,000 ir	
	Integrated Family deductible	N/A		\$13,800\$14,000 integr	
	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	\$7,800 <u>\$8,200</u>		See endne	ote
	Family Out-of-pocket maximum	\$15,600 <u>\$16,40</u>	<u>0</u>	See endne	ote
HSA plan: Self-only coverage deductible				\$ 6,900 \$7,0	
	HSA family plan: Individual deductible	N/A	l	\$ 6,900 \$7,0	<u>000</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	Other practitioner office visit	\$65	After 1st three non-	0%	X
office or clinic			preventive visits After 1st three non-		
visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Test	Laboratory Tests	\$40		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	Z	0%	X
	Tier 1	\$18	Pharmacy Deductible	0%	X
Drugs to treat	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
illness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	X
CONTRIBUTI	Tier 3	pharmacy deductible	Deductible	U%	^
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Surgery facility fee (e.g., ASC)	40%	X	0%	Х
Outpatient services	Physician/surgeon fees	40%	×	0%	X
301 11003	Outpatient visit	40%	×	0%	X
	Emergency room facility fee (waived if admitted)	40%	×	0%	Х
Need	Emergency room physician fee (waived if admitted)	No charge		0%	X
immediate attention	Medical transportation (including emergency and non-emergency)	40%	x	0%	×
	Urgent care	\$65	After 1st three non-	0%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	preventive visits	0%	X
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	40%	X	0%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	Х
health, or			proventive violes		
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%	Х
recovering or other special	Skilled nursing care	40%	×	0%	x
health needs	Durable medical equipment	40%	x	0%	X
	Hospice service	No charge		0%	X
	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				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
Preventive					
	Topical Fluoride Application				
	Space Maintainers - Fixed Restorative Procedures				
Child Dental Basic Services		Not Covered		Not Covered	
, 23,11030	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics			NI-10	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	trophic Plan
ctuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible		
	Integrated Family deductible	\$16,300 <u>\$1</u>	7,100 integrated N/A
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A N/A
	Individual Out-of-pocket maximum	\$8.1	1 50 \$8,550
	Family Out-of-pocket maximum		300 <u>\$17,100</u>
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no preventive visits
	Other practitioner office visit	0%	After 1st three no preventive visits
visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
Drugs to treat	Tier 2	0%	X
condition	Tier 3	0%	x
	Tier 4	0%	x
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X
	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 attention	Medical transportation (including emergency and non-emergency)	0%	X
	Urgent care	0%	After 1st three no
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	X
	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 no
behavioral	visits	0%	preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	items and services	0%	Х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
Child Dental Diagnostic and Preventive	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
01.11.15	Restorative Procedures		
Child Dental Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
		I	
Child Dental	Periodontics (other than maintenance)	Not Covered	
Child Dental Major Services	Periodontics (other than maintenance) Prosthodontics	Not Covered	
	Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered	

Endnotes to Covered California <u>2020-2021</u> 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.
- 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 20202021 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.	
2	1) Non-preferred generic drugs;	
	2) Preferred brand name drugs; and	
	3) Any other drugs recommended by the plan's	
	pharmaceutical and therapeutics (P&T) committee based on	
	drug safety, efficacy and cost.	
3	Non-preferred brand name drugs or;	
	Drugs that are recommended by P&T committee based	
	on drug safety, efficacy and cost or;	
	Generally have a preferred and often less costly	
	therapeutic alternative at a lower tier.	
4	Drugs that are biologics and drugs that the Food and	
	Drug Administration (FDA) or drug manufacturer requires to	
	be distributed through specialty pharmacies;	
	2) Drugs that require the enrollee to have special training or	
	clinical monitoring;	
	3) Drugs that cost the health plan (net of rebates) more than	
	six hundred dollars (\$600) net of rebates for a one-month	
	supply.	

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 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 <u>Bronze and Bronze HDHP is are</u> 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 <u>2020-2021</u> calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.