Covered California 2020 2021 Patient-Centered Benefit Plan Designs¹

Final Board-approved Proposed May 16, 2019 January 16, 2020

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

10.0 EHB

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



Summary of Ber	nefits and Coverage	ŤI	M		
	amounts describe the Enrollee's out of pocket costs.	Individual-only		Individual-only	
	·	Coinsurance		Copay Pla	
Actuarial Value - A		91.7 <u>91.6%</u>	<u>o</u>	89.1<u>89.3</u>%	o .
	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	
	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	
provider's office or	Other practitioner office visit	\$15		\$15	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	,				
	Tier 1	\$5		\$5	
Drugs to	Tier 2	\$15		\$15	
treat illness or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	Current facility for /o a. ASC)	·		·	
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	
immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	·		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
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	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	No charge		No charge	
Preventive					
	Topical Fluoride Application				
	Space Maintainers - Fixed			_	
Child Dental Basic	Restorative Procedures	20%		See 20202021 Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Obilet De 1	Endodontics			0 0000000	
Child Dental Major	Periodontics (other than maintenance)	50%		See 20202021 Dental Copay	
Services	Prosthodontics			Schedule	
		· ·		1	I
Child	Oral Surgery Medically necessary orthodontics	50%		\$1,000	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum		CCSB-onl Platinum	ī
	·	Coinsurance 91.7%90.6		Copay Pla 89.1%88.1	
ctuarial Value - A			<u>70</u>		<u>70</u>
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$250 / \$0 /	/ \$0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$500 / \$0 /		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$4,500		\$4,500 <u>\$4,0</u>	<u>00</u>
	Family Out-of-pocket maximum	\$9,000		\$ 9,000 \$8,0	<u>00</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15 <u>\$20</u>	
Health care provider's office or	Other practitioner office visit	\$15		\$15 <u>\$20</u>	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15\$2 <u>0</u>	
Tests	X-rays and Diagnostic Imaging	\$30		\$30 <u>\$40</u>	
	Imaging (CT/PET scans, MRIs)	10%	<u>X</u>	\$75 <u>\$150</u>	
			<u> </u>		
	Tier 1	\$5		\$5	
Drugs to treat illness	Tier 2	\$15 <u>\$30</u>		\$15	
or condition	Tier 3	\$ 25 \$50		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%	<u>X</u>	\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$ 150 \$250	<u>x</u>	\$150 <u>\$250</u>	
Need immediate attention	Emergency room physician fee (waived if admitted)	No charge	_	No charge	
	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention	Urgent care	\$15			
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	Ф 15		\$15 <u>\$20</u> \$250 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%	<u>X</u> <u>X</u>	5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$15		\$15 <u>\$20</u>	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient 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%	<u>X</u>	\$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	
Juit	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dontal	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	i vo cilaige		ivo cilaige	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 20202021	
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental		50%		See 20202021 Dental Copay	
Major Services	Periodontics (other than maintenance)	JU 70		Schedule	
	Prosthodontics				
Child	Oral Surgery				
Child	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	
ctuarial Value - A	V Calculator	81.8% <u>81.9</u> °		78.3% <u>78.1</u>	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$7,800 <u>\$7,95</u>		\$7,800 <u>\$7,9</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		900	\$15,600 <u>\$15,</u> N/A	<u>900</u>
	HSA family plan: Individual deductible			N/A	
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	\$30 <u>\$35</u>		\$30 <u>\$35</u>	
Health care provider's	Other practitioner office visit	\$30 <u>\$35</u>		\$30 <u>\$35</u>	
office or clinic 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\$16		\$15 <u>\$16</u>	
Drugs to treat illness	Tier 2	\$55		\$55	
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%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$30 \$35		\$30 <u>\$35</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%		\$600 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%		5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	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 <u>\$35</u>		\$30 <u>\$35</u>	
recovering or other special	Skilled nursing care	20%		\$300 per day up to	
nealth needs	Durable medical equipment	20%		5 days 20%	
	Hospice service	No charge		No charge	
Child over	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	590		590	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2020 2021	
Basic	Periodontal Maintenance Services	20%		Dental Copay	
Services	Periodontal Maintenance Services Crowns and Casts			Schedule	
Child Dental	Endodontics	F00/		See <u>20202021</u>	
Major Services	Periodontics (other than maintenance)	50%		Dental Copay Schedule	
	Prosthodontics				
Okild	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Summary of Bei	nefits and Coverage	CCSB-only		CCSB-only	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan		Gold Copay Plan	
Actuarial Value - A	V Calculator	78.1%	II.	79.7%79.4%	
Actuariar value - A	Plan design includes a deductible?	Yes, Medical/Pharm	acv	Yes, Medical/Pharr	macv
	Integrated Individual deductible	N/A	асу	N/A	nacy
	Integrated Framily deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 250 \$500 / \$ 0 \$250 /	\$0	\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$500 <u>\$1,000</u> / \$0 <u>\$500</u>		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800 \$6,400		\$7,800	
	Family Out-of-pocket maximum	\$ 15,600 \$12,800		\$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 \$30		\$25 \$35	
Health care	Other and the control of the control of	405400		405405	
provider's office or	Other practitioner office visit	\$25 <u>\$30</u>		\$25 <u>\$35</u>	
clinic visit	Specialist visit	\$50		\$50 <u>\$55</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25 <u>\$30</u>		\$25 \$35	
Tests	X-rays and Diagnostic Imaging	\$65 <u>\$50</u>		\$65 \$55	
	Imaging (CT/PET scans, MRIs)	20%	X	\$275 <u>\$250</u>	<u>X</u>
	Tier 1	\$15		\$15	
		υιψ		ΨΙΟ	
Drugs to	Tier 2	\$50 <u>\$40</u>	<u>X</u>	\$ 50 \$40	
treat illness or condition	Tier 3	\$80 <u>\$70</u>	X	\$ 80 \$70	
	Tier 4	20% up to \$250 per script	X	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%	<u>X</u>	\$300	<u>X</u>
Outpatient services	Physician/surgeon fees	20%		\$40 <u>\$35</u>	
	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	Medical transportation (including emergency and non-emergency)	\$250	x	\$250	Х
attention			^	·	^
	Urgent care	\$25 <u>\$30</u>		\$25 <u>\$35</u>	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	Х
,	Physician/surgeon fee	20%	х	No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	#25#20		#25#25	
health, behavioral	visits	\$25 <u>\$30</u>		\$25 <u>\$35</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	405400		405405	
abuse needs	items and services	\$25 <u>\$30</u>		\$25 <u>\$35</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$30		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25 \$30		\$ <u>25\$35</u>	
recovering or	Skilled nursing care	20%	×		Х
other special health needs			^	\$300 per day up to 5 days	^
	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	<u>.</u>			
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		20%		See 20202021 Dental Copay Schedule	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics			See 2020 2021 Dental Copay	
Major Services	Periodontics (other than maintenance)	50%		See 20202021 Dental Copay Schedule	
23111303	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	
Orthodontics				. ,	

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

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Summary of	Benefits	and Cove	rage	

	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
Actuarial Value - A	.V Calculator	71.8% 71.0%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	,
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$6	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$6	0
	Individual Out–of–pocket maximum	\$7,800 <u>\$7,950</u>	
	Family Out-of-pocket maximum	\$ 15,600 \$15,900	
	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	Chariellet visit	# 00	
Cillic visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	51
	Tier 1	\$16	Pharmacy deductible
Duranata	Tier 2	\$60	Pharmacy
Drugs to treat illness		·	deductible Pharmacy
or condition	Tier 3	\$90	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%	
	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	20%	X
Hospital stay	delivery, mental health, and substance use)		^
Mental	Physician/surgeon fee	20%	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$40	
recovering or other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
01.11.1	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 Orlange	
	Preventive - Cleaning		
Child Dental			
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
01 11 1 7	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%	
23.1.300	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	
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10.0 EHB

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

	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%		70.2%69.4%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy
	Integrated Framily deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$6)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0	ı	\$4,500 / \$600 / \$6)
	Individual Out-of-pocket maximum	\$7,800 <u>\$7,950</u>		\$7,800 <u>\$7,950</u>	
	Family Out-of-pocket maximum	\$15,600 <u>\$15,900</u>		\$15,600 <u>\$15,900</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	\$50		\$ 50 <u>\$60</u>	
provider's	Other practitioner office visit	\$50		\$50 <u>\$60</u>	
office or clinic visit	Specialist visit	\$85		\$85 <u>\$90</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40 <u>\$50</u>		\$40 <u>\$60</u>	
Tests	X-rays and Diagnostic Imaging	\$85		\$85 <u>\$90</u>	
	Imaging (CT/PET scans, MRIs)	20% 35%	<u>x</u>	\$300	X
			Pharmacy		Pharmacy
	Tier 1	\$17 <u>\$20</u>	deductible	\$17 <u>\$20</u>	deductible
Drugs to	Tier 2	\$65 <u>\$70</u>	Pharmacy deductible	\$65 <u>\$80</u>	Pharmacy deductible
treat illness or condition	Tier 3	\$90 <u>\$100</u>	Pharmacy deductible	\$90 <u>\$110</u>	Pharmacy deductible
	Tier 4	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20% 35%	<u>X</u>	20% 35%	<u>X</u>
Outpatient	Physician/surgeon fees	20% 35%		20% 35%	
services	Outpatient visit	20% 35%		20% 35%	
	Emergency room facility fee (waived if admitted)	\$4 00 \$35%	X	\$400\$35%	X
Need	Emergency room physician fee (waived if admitted)	No charge	,	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 <u>\$60</u>	
Hospital stay	delivery, mental health, and substance use)	20% 35%	X	20% 35%	X
	Physician/surgeon fee	20% 35%	X	20% 35%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$50 <u>\$60</u>	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$50 <u>\$60</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20% 35%		\$45	
Ha!	Outpatient Rehabilitation and Habilitation services	\$50		\$50\$60	
Help recovering or				_	
other special health needs	Skilled nursing care	20% 35%	X	20% 35%	X
	Durable medical equipment	20% 35%		20% 35%	
	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				
Child Day (a)	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 Charge		140 Charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	2000		See 2020 2021 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		Schedule Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 20202021 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	· ·				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

	nefits and Coverage	CCSB-or	nly
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver HDHP PI	
Actuarial Value - A	V Calculator	71.3% <u>71.</u>	
	Plan design includes a deductible?	Yes, integr	ated
	Integrated Individual deductible	\$2,500 integ	grated
	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	\$13,700 \$2,500	
	HSA family plan: Individual deductible	See endn	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
LVent	Primary care visit to treat an injury, illness, or condition	20%	Х
Health care			
provider's office or	Other practitioner office visit	20%	Х
clinic visit	Specialist visit	20%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	Х
Tests	X-rays and Diagnostic Imaging	20%	Х
	Imaging (CT/PET scans, MRIs)	20%	Х
	Tier 1	20% up to \$250 per script	х
	Tier 2	20% up to \$250 per	_
Drugs to treat illness	Her Z	script	Х
or condition	Tier 3	20% up to \$250 per script	Х
	Tier 4	20% up to \$250 per script	×
	Surgery facility fee (e.g., ASC)	20%	Х
Outpatient services	Physician/surgeon fees	20%	Х
00.11000	Outpatient visit	20%	Х
	Emergency room facility fee (waived if admitted)	20%	Х
Need	Emergency room physician fee (waived if admitted)	0%	Х
immediate attention	Medical transportation (including emergency and non-emergency)	20%	Х
	Urgent care	20%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	Х
Hospital stay	delivery, mental health, and substance use)		
Mental	Physician/surgeon fee	20%	Х
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%	Х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	Х
Help	Outpatient Rehabilitation and Habilitation services	20%	Х
recovering or	Skilled nursing care	20%	X
other special health needs	Durable medical equipment	20%	X
	Hospice service	20%	X
	Eye exam		^
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	oral Exam	No charge	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Okiid D	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		
OLUL :	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPL	
ctuarial Value - A	V Calculator	94.5% <u>94.1%</u>		87.7%87.9%	
	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 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/\$0	\$2,800 / \$200 / \$0)
	Individual Out-of-pocket maximum	\$1,00	0	\$2,700 <u>\$2,750</u>	
	Family Out-of-pocket maximum	\$2,00	0	\$ 5,400 \$ <u>5,500</u>	
	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
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care 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\$10	
	Tier 2	\$3 \$10		\$5 \$10 \$25	Pharmacy
Drugs to treat illness or condition	Tier 3	\$15		\$45	deductible Pharmacy
or condition		10% up to \$150 per		15% up to \$150 per script after	deductible Pharmacy
	Tier 4	script		pharmacy deductible	deductible
0.1	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
Need	Emergency room facility fee (waived if admitted)	\$50		\$ 150 \$175	
	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		V		V
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%	X	15%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	x	15%	Х
other special health needs					^
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
Cai t	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dont-1	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 Griarye		140 onaige	
	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	0070		0070	
Child	Oral Surgery				
	Medically necessary orthodontics	50%		50%	

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-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
tuarial Value - A	V Calculator	73.9% <u>73.6%</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	\$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	Deductib Applies
Haalkh aana	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	
			Pharma
	Tier 1	\$16	deductik
Drugs to	Tier 2	\$55	Pharma deductik
treat illness	Tier 3	\$85	Pharma
			deductik
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductik
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	•	
attention		\$250	
	Urgent care	\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office		
health, behavioral health, or	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	
	·	-	
Child eye care	1 pair of glasses per year (or contact lenses in liquid glasses)	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	Ŭ	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	200/	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental	Periodontics (other than maintenance)	50%	
Major			
Major Services	Prosthodontics		
•	Prosthodontics Oral Surgery		

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze	
tuarial Value - A\	·	61.4% <u>64.85%</u>		HDHP Plate 62.1% 64.69	
	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integrat	
	Integrated Individual deductible	N/A	•	\$ 6,900 \$7,000 into	
	Integrated Family deductible	N/A		\$13,800 <u>\$14,000</u> in	tegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / <mark>\$500<u>\$750</u></mark>	/ \$0	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 <u>\$1,5</u> 1	<u>00</u> / \$0	N/A	
	Individual Out–of–pocket maximum	\$7,800 <u>\$7,950</u>		See endnot	te
	Family Out-of-pocket maximum	\$15,600 <u>\$15,900</u>	<u>)</u>	See endnot	te
	HSA plan: Self-only coverage deductible	N/A		\$ 6,900 \$7,00	
	HSA family plan: Individual deductible	N/A		\$6,900 <u>\$7,00</u>	<u>00</u>
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	\$65 <u>\$85</u>	After 1st three non- preventive visits	0%	Х
Health care provider's	Other practitioner office visit	\$65 <u>\$85</u>	After 1st three non-	0%	X
office or clinic visit	Specialist visit	_	preventive visits After 1st three non-	001	
milic visit	Specialist visit	\$95 <u>\$115</u>	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40	X	0%	Х
ests	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
	Tier 2	40% up to \$500 per script after	Pharmacy	00/	
rugs to reat illness	Tier 2	pharmacy deductible	Deductible	0%	X
r condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
	Tier 4	40% up to \$500 per script after	Pharmacy	0%	
	11 01 7	pharmacy deductible	Deductible	U76	Х
	Surgery facility fee (e.g., ASC)	40%	×	0%	Х
Outpatient services	Physician/surgeon fees	40%	×	0%	Х
	Outpatient visit	40%	x	0%	х
	Emergency room facility fee (waived if admitted)	40%	×	0%	х
eed	Emergency room physician fee (waived if admitted)	No charge		0%	х
nmediate ttention	Medical transportation (including emergency and non-emergency)	40%	×	0%	X
	Urgent care	\$65\$85	After 1st three non-	0%	×
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	_	preventive visits		
ospital stay	delivery, mental health, and substance use)	40%	X	0%	Х
	Physician/surgeon fee	40%	X	0%	Х
lental ealth, ehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65 <u>\$85</u>	After 1st three non- preventive visits	0%	х
ealth, or ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65 <u>\$85</u>	×	0%	x
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	х
elp	Outpatient Rehabilitation and Habilitation services	\$65 <u>\$85</u>		0%	х
ecovering or	Skilled nursing care	40%	×	0%	x
ther special ealth needs					
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	Х
hild eye are	Eye exam	No charge		No charge	
ai e	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
hild D	Preventive - Cleaning				
hild Dental liagnostic	Preventive - X-ray	No oborgo		No oberes	
nd reventive	Sealants per Tooth	No charge		No charge	
3.011.140	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
asic ervices	Periodontal Maintenance Services	20%		20%	
51 11003	Crowns and Casts				
Child Dental	Endodontics	500/		500/	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

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•	2019 <u>January 16, 2020</u>		
-	nefits and Coverage	Cotoo	turankia Dian
	amounts describe the Enrollee's out of pocket costs.	Catasi	trophic Plan
Actuarial Value - A		V	
	Plan design includes a deductible? Integrated Individual deductible	Yes, integrated \$8,150\$8,300 integrated	
	Integrated Family deductible		6,600 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	,	N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	\$8, ´	1 50 \$8,300
	Family Out-of-pocket maximum	\$16,3	3 00 \$16,600
	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	0%	After 1st three non- preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three non-
office or	0		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%	×
D	Tier 2	0%	X
Drugs to treat illness	1101 2	070	^
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
	·	0%	X
Nood	Emergency room facility fee (waived if admitted)		*
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	0%	X After 1st three non-
	Urgent care	0%	preventive visits
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	x
Mental	Mental/behavioral health and substance use disorder outpatient office	0%	After 1st three non-
health, behavioral	visits	0%	preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	X
abuse needs	items and services	070	^
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	×
Help	Outpatient Rehabilitation and Habilitation services	0%	×
recovering or other special	Skilled nursing care	0%	x
health needs	Durable medical equipment	0%	x
	Hospice service	0%	x
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	x
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	0%	×
Services			
	Crowns and Casts		
Child Dental	Endodontics	001	
Major Services	Periodontics (other than maintenance)	0%	X
	Prosthodontics		
Child	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	0%	X

Date: May 16, 2019 January 16, 2020

Summary of Benefits and Coverage



Member Cost Share amounts describe the Enrollee's out of pocket costs.		Individual-only Platinum Coinsurance Plan		Individual-only Platinum Copay Plan		
Actuarial Value - A\	/ Calculator	91.791.69			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/\$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		
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	Other practitioner office visit	\$15		\$15		
provider's office or	Other practitioner office visit	φισ		φισ		
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 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	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$150		\$150		
Nood						
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		
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15		
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 other special	Skilled nursing care	10%		\$150 per day up to		
health needs	Durable medical equipment	10%		5 days 10%		
	* *					
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
Juilo	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Obild Day of the	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
and Preventive	Sealants per Tooth	NOT COVELED		INOL COVERED		
110101111110	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					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		
Orthodontics						

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Summary of Ber	nefits and Coverage	CCSB-onl Platinum		<u>CCSB-onl</u> Platinum	_
	amounts describe the Enrollee's out of pocket costs.	Coinsurance		Copay Pla	
Actuarial Value - A\		91.7% 90.6	<u>%</u>	89.1% <u>88.1</u>	<u>%</u>
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$250</u> / \$0	\$0	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 <u>\$500</u> / \$0 /	\$0	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$4,500		\$4 <u>,500</u> \$4,0	<u>00</u>
	Family Out-of-pocket maximum	\$9,000		\$ 9,000 \$8.0	<u>00</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15 <u>\$20</u>	
Health care provider's	Other practitioner office visit	\$15		\$15 <u>\$20</u>	
office or clinic 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 <u>\$40</u>	
	Imaging (CT/PET scans, MRIs)	10%	<u>X</u>	\$75 <u>\$150</u>	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15 \$30		\$15	
illness or condition	Tier 3			·	
condition		\$25 <u>\$50</u> 10% up to \$250 per		\$25 10% up to \$250 per	
	Tier 4	script		script	
Outpatient	Surgery facility fee (e.g., ASC)	10%	X	\$100	
services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150 <u>\$250</u>	X	\$150 <u>\$250</u>	
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%	<u>×</u>	\$250 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%	<u>X</u>	No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15 \$20	
behavioral health, or	visits	,		, , , , , , , , , , , , , , , , , , ,	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient 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	Skilled nursing care	10%	X	\$150 per day up to	
other special health needs	Durable medical equipment	10%	_	5 days 10%	
	Hospice service	No charge		No charge	
4	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	. 10 Sharge		. 10 Sharge	
	Preventive - Cleaning				
Child Dental	Preventive - Clearing Preventive - X-ray				
Diagnostic and		No charge		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		Not Covered	
33111003	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		Not Covered	
Services	Prosthodontics	5570		Govereu	
	Oral Surgery				
Child		500/		N (2	
Orthodontics	Medically necessary orthodontics	50%		Not Covered	

20202021 Patient-Centered Benefit Plan Designs 9.5 EHB Date: May 16, 2019 January 16, 2020

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	e e e e e e e e e e e e e e e e e e e
Actuarial Value - A	V Calculator	81.8% <u>81.9</u> °		78.3% <u>78.1</u>	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out–of–pocket maximum Family Out-of-pocket maximum			\$7,800 <u>\$7,9</u> \$15,600 <u>\$</u> 15,	
	HSA plan: Self-only coverage deductible		<u>900</u>	N/A	<u>300</u>
	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	\$30 <u>\$35</u>		\$30 <u>\$35</u>	
Health care	Other practitioner office visit	\$20\$2E		\$20\$25	
provider's office or	Other practitioner office visit	\$30 <u>\$35</u>		\$30 <u>\$35</u>	
clinic 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 <u>\$16</u>		\$15 <u>\$16</u>	
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	
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 attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$30\$35		\$30\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	<u></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 health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$30 <u>\$35</u>		\$30 \$35	
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 <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	
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	
231000	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics	, tot Govereu		, tot Govereu	
	Oral Surgery				
Child	• •				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Community Comm	-	Summary of Benefits and Coverage			CCSB-only Gold		
Promoting the part of the pa		·		n	Copay Plan		
Minimum	Actuarial Value - A						
Part		·		acy	,	nacy	
Persist youngeable NOT integrated Reface of Planmeny Cheels 1500 1							
Inches I		Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$250 \$500 / \$0 \$250 /	\$0			
Common		Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$500 <u>\$1,000</u> / \$0 <u>\$500</u>	/ \$0	\$500 / \$0 / \$0		
Part		Individual Out-of-pocket maximum					
Comman			· -		·		
Privacy core visit to fore an injury, thesis, or constitue Providers office or include the providers of the control injury and the contr		· · · · ·					
Mainter care of the control of the		Service Type	Member Cost Share		Member Cost Share		
providers of children with special to tax control of children with special to tax cont		Primary care visit to treat an injury, illness, or condition	\$25 <u>\$30</u>		\$25 <u>\$35</u>		
Specialist vall Specialist	provider's	Other practitioner office visit	\$25 <u>\$30</u>		\$25 <u>\$35</u>		
Lebersulary Tracks K-rays and Diagnetic Imaging times and properties (as a series of trace) Ter 1 Ter 1 Ter 2 Ter 1 Ter 2 Surgary facility fee (e.g., ASC) Ter 3 Surgary facility fee (e.g., ASC) Ter 4 Surgary facility fee (e.g., ASC) Physitanineuropon fees Outpatients Emergency room facility fee (easeled of admitted) Emergency room facility fee (easeled of admitted) Emergency room facility fee (easeled of admitted) Medical interportation (reluding emergency and rare emergency) Urgare care Hospital etary Feeting Vac (e.g., Pospital room) for impatient etary (notuling lation and desired many feeting and emergency) Urgare care Hospital etary Frequency Home hashith, benth with a feeting of the province of the control of the province of the control of the province of the control of the control of the province of the control of the contro		Specialist visit	\$50		\$50\$5 <u>5</u>		
Lebersulary Tracks K-rays and Diagnetic Imaging times and properties (as a series of trace) Ter 1 Ter 1 Ter 2 Ter 1 Ter 2 Surgary facility fee (e.g., ASC) Ter 3 Surgary facility fee (e.g., ASC) Ter 4 Surgary facility fee (e.g., ASC) Physitanineuropon fees Outpatients Emergency room facility fee (easeled of admitted) Emergency room facility fee (easeled of admitted) Emergency room facility fee (easeled of admitted) Medical interportation (reluding emergency and rare emergency) Urgare care Hospital etary Feeting Vac (e.g., Pospital room) for impatient etary (notuling lation and desired many feeting and emergency) Urgare care Hospital etary Frequency Home hashith, benth with a feeting of the province of the control of the province of the control of the province of the control of the control of the province of the control of the contro		Preventive care/ screening/ immunization	No charge		No charge		
The 1 Text 1 Text 2 Text 3 Text 4 Tex		-	-		-		
The 1 St 0 SOURCE STORES IN THE 2 SOURCE STORES OF THE 2 SOURCE STORES OF THE 3 SOURCE STOR	Tests	X-rays and Diagnostic Imaging	\$65 <u>\$50</u>		\$65 <u>\$55</u>		
The 2 stages of condition The 3 stages of condition The 4 20% up to 5250 per script Surgery facility fee (e.g., ASC) 20% up to 5250 per script Surgery facility fee (e.g., ASC) 20% up to 5250 per script Surgery facility fee (e.g., ASC) 20% up to 5250 per script Surgery facility fee (e.g., ASC) 20% up to 5250 per script Surgery facility fee (e.g., ASC) 20% up to 5250 per script Emergency proof facility fee (washed if admitted) 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%		Imaging (CT/PET scans, MRIs)	20%	X	\$275 <u>\$250</u>	<u>X</u>	
Time 4 20% up to \$250 per script Time 4 20% up to \$250 per script Surgey facility fee (e.g., ASC) 20% up to \$250 per script Physiciant surgeon fees Dupoillent violit Record Immediate attention Media Immediate attention Heapth (e.g., ASC) 20% up to \$250 per script Emergency room facility fee (e.g., ASC) 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%		Tier 1	\$15		\$15		
Tiles 3 Surgey facility fee (e.g., ASC) Outpatient early fee (e.g., ASC) Surgey facility fee (e.g., ASC) Outpatient early fee (e.g., ASC) Surgey facility fee (e.g., ASC) Physician requested for a facility fee (e.g., ASC) Dubatient visit Emergency room facility fee (valved if admitted) Emergency room facility fee (valved if admitted) Emergency room physician fee (valved if admitted) No charge Read Emergency room physician fee (valved if admitted) No charge No charge No charge No charge Final facility fee (e.g., ASC) X SSSO X Hospital stay Hospital stay Hospital stay Final facility fee (e.g., ASC) No charge No charge SSSSSS X SSSO X SSSO X SSSO X SSSO X SSSSSS X SSSSSS X SSSSSS X SSSSSS	Drugs to treat	Tier 2	\$50 \$40	×	\$ 50 \$40		
Ter 4 20% up to \$250 per script	illness or	Tier 3					
Surgery facility fee (e.g., ASC) Outpatient services Outpatient year (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room facility fee (waved if admitted) Emergency room facility fee (waved if admitted) Emergency room facility fee (waved if admitted) Medical transportation (including emergency and non-emergency) Urgent care Hospital stay Hospital stay Hospital stay Hospital stay Hospital stay Mental health, periodinal surgeon fee Mortal health and substance use disorder outpatient office visits Mortal health and substance use disorder ober outpatient office visits Mortal health area (cost ahare per visit) Asia Sail Sail Sail Sail Sail Sail Sail Sa							
Dutpation tay record from the services of the							
Projuction results of the comment of	Outpatient			<u>X</u>		<u>X</u>	
Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Medical transportation (including mergency and non-emergency) Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mertal health and substance use) Facility fee (e.g. hospital room) fo	services	, ,					
Emergency room physician fee (walved if admitted) No charge No charge No charge		·					
Amendate attention Medical transportation (including emergency and non-emergency) Litigant care Facility fee (e.g., hospital room) for inpatient stary (including labor and delivery, mental health, and substance use) Physicianhurgeon fee Mental health, or substance abuse needs Pregnancy Pregnancy Pregnancy Prenatal care and preconception vists No charge Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder other outpatient liems and services Mental behavioral health and substance use disorder other outpatient liems and services Mental behavioral health and substance use disorder other outpatient liems and services Mental behavioral health and substance use disorder other outpatient liems and services Mental behavioral health and substance use disorder other outpatient liems and services Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder outpatient office vists Mental behavioral health and substance use disorder outpatient office Sassand services Skilled nursing care Applied Health and Sassan outpatient services No charge			<u>\$25020%</u>	X	\$250	Х	
Urgent care		Emergency room physician fee (waived if admitted)	No charge		No charge		
Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, merital health, and substance use) 20% X No charge	attention	Medical transportation (including emergency and non-emergency)	\$250	X	\$250	X	
delivery, mental health, and substance use) Mental health, and substance use disorder outpatient office total health, or substance buse needs leath, or substance abuse needs leath, or substance abuse needs leath or substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient leath and services Mental/behavioral health and substance use disorder other outpatient leath and services Mental/behavioral health and substance use disorder other outpatient leath and services Mental/behavioral health and substance use disorder other outpatient leath and services Mental/behavioral health and substance use disorder other outpatient leath and services Mental/behavioral health and substance use disorder other outpatient leath and services No charge No charge No charge No charge Skilled nursing care Durable medical equipment Hospice service No charge No c		•	\$25 <u>\$30</u>		\$25 <u>\$35</u>		
Mental health, behavioral health and substance use disorder outpatient office visits health, or substance abuse needs abuse needs. Mental/behavioral health and substance use disorder other outpatient items and services. Mental/behavioral health and substance use disorder other outpatient items and services. Mental/behavioral health and substance use disorder other outpatient items and services. Pregnancy Pregnancy Help recovering or other special health care (cost share per visit) Salo 330 Salo 330 Willed nursing care Urubal emedical equipment 20% X \$300 per day up to 5 days X hos charge No charge	Hospital stay		20%	X	\$600 per day up to 5 days	Х	
behavioral health, or substance abuse needs Pregnancy Pregnancy Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Sa30 Sa30 Sa50 Sa5535 S		Physician/surgeon fee	20%	X	No charge		
Items and services Sa6530 Sa6535 Sa6535 Pregnancy Prenatal care and preconception visits No charge No charge	behavioral	·	\$25 <u>\$30</u>		\$25 <u>\$35</u>		
Home health care (cost share per visit) Holp recovering or other special reaction and Habilitation services Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Child Dental Major or Crowns and Casts Endodontics Oral Surgery Child Dental Major or Crowns and Casts Endodontics Oral Surgery Child Dental Major or Crowns and Casts Endodontics Oral Surgery Child Dental Major or Crowns and Casts Endodontics Oral Surgery Child Dental Major or Crowns and Casts Endodontics Oral Surgery Child Dental Major or Services Periodontal Maintenance Services Oral Surgery Child Dental Major or Services Periodontics Oral Surgery Child Dental Major or Services Prostation or Services Not Covered		·	\$ 25 \$30		\$ 25 \$35		
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Child Dental Major Services Crowns and Casts Child Dental Major Services Crowns and Casts Child Dental Services Crowns and Casts Crowns and Cas	Pregnancy	Prenatal care and preconception visits	No charge		No charge		
Skilled nursing care other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child bental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Endodontics Oral Surgery Child Dental Basic Services Crowns and Casts Endodontics Oral Surgery Child Dental Major Services Crowns and Casts Endodontics Oral Surgery Child Dental Major Services Crowns and Casts Endodontics Oral Surgery Child Medically persessary orthodostics Not Covered		Home health care (cost share per visit)	\$30		\$30		
Skilled nursing care 20% X \$300 per day up to 5 days X	Help	Outpatient Rehabilitation and Habilitation services	\$25 <u>\$30</u>		\$25 <u>\$35</u>		
health needs health needs Durable medical equipment Hospice service Child eye	recovering or	Skilled nursing care	20%	x	\$300 per day up to 5 days	Х	
Hospice service Child eye care I pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressen orthodontics Oral Surgery No charge Not Covered		Durable medical equipment	20%				
Child ve care Eye exam			No charge		No charge		
Child Dental Diagnostic and Preventive - Cleaning Preventive - Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Major Services Corowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered	Child eve	Eye exam	-		-		
Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Not Covered Not Covered Not Covered Periodontal Maintenance Services Periodontics (other than maintenance) Not Covered Not Covered Not Covered Prosthodontics Oral Surgery		1 pair of glasses per year (or contact lenses in lieu of glasses)	_		_		
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered		Oral Exam					
Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered		Preventive - Cleaning					
and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered		Preventive - X-ray	N · O		N. 6		
Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered	and	Sealants per Tooth	Not Covered		Not Covered		
Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered	i revenuve	Topical Fluoride Application					
Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered		Space Maintainers - Fixed					
Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered		Restorative Procedures	No. C		No. Co.		
Child Dental Major Periodontics (other than maintenance) Not Covered Not Covered Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered N		Periodontal Maintenance Services	Not Covered		Not Covered		
Child Dental Major Services Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered Not Covered		Crowns and Casts					
Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered	Child Dontal	Endodontics					
Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered	Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Child Medically necessary orthodontics Not Covered Not Covered	Services	Prosthodontics					
		Oral Surgery					
		Medically necessary orthodontics	Not Covered		Not Covered		

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	Plan
tuarial Value - A\	/ Calculator	71.8% 71.0%	
	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 / \$6)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$6)
	Individual Out-of-pocket maximum	\$7,800 <u>\$7,950</u>	
	Family Out-of-pocket maximum	\$15,600 <u>\$15,900</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
Hoolth care	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's office or	Other practitioner office visit	\$40	
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	Pharma deductil
Drugs to treat	Tier 2	\$60	Pharma deductil
condition	Tier 3	\$90	Pharma deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductik
	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		.,
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office		
behavioral health, or	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%	Х
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	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered	
Ser vices	Crowns and Casts		
	Endodontics		
		Not Covered	
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered	
Major		Not Covered	

Summary of Benefits and Coverage		CCSB-only		CCSB-only		
Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan	1	Silver Copay Plan		
Actuarial Value - A\	/ Calculator	70.5% <u>70.2%</u>		70.2% 69.4%		
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy	
	Integrated Individual deductible	N/A		N/A		
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$6		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$6	0	
	Individual Out–of–pocket maximum Family Out-of-pocket maximum	\$7,800 <u>\$7,950</u> \$15,600		\$7,800 <u>\$7,950</u> \$15,600 <u>\$15,900</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>\$60</u>		
Health care	Other practitioner office visit	\$50		\$50 <u>\$60</u>		
provider's office or	Other practitioner office visit	φου		\$30 \$00		
clinic visit	Specialist visit	\$85		\$85 <u>\$90</u>		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$40 <u>\$50</u>		\$40 \$60		
Tests	X-rays and Diagnostic Imaging	\$85		\$85 <u>\$90</u>		
	Imaging (CT/PET scans, MRIs)	20% 35%	<u>X</u>	\$300	X	
	Tier 1	\$17 <u>\$20</u>	Pharmacy deductible	\$17 <u>\$20</u>	Pharmacy deductible	
Drugs to treat	Tier 2	\$65 \$70	Pharmacy deductible	\$65<u>\$</u>80	Pharmacy deductible	
illness or condition	Tier 3	\$00\$400	Pharmacy	¢00¢440	Pharmacy	
Condition	Hel 3	\$ 90 \$100	deductible	\$ 90 \$110	deductible	
	Tier 4	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20%35% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
	Surgery facility fee (e.g., ASC)	20% 35%	<u>X</u>	20% 35%	<u>X</u>	
Outpatient services	Physician/surgeon fees	20% 35%		20% 35%		
00.11000	Outpatient visit	20% 35%		20% 35%		
	Emergency room facility fee (waived if admitted)	\$400 <u>\$35%</u>	X	\$400 <u>\$35%</u>	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	Х	
	Urgent care	\$50		\$50\$60		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%35%	Х	20% 35%	Х	
Hospital stay	delivery, mental health, and substance use)				Λ	
	Physician/surgeon fee	20% 35%	Х	20% 35%		
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$ 50 <u>\$60</u>		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$ 50 \$60		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20% 35%		\$45		
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$50 \$60		
recovering or other special	Skilled nursing care	20% 35%	X	20% 35%	Х	
health needs	Durable medical equipment	20% 35%		20% 35%		
	Hospice service	No charge		No charge		
Ohild	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	rio dilaigo		i to diango		
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic and		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					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
Ok "III	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		

	2019 January 16, 2020 efits and Coverage	CCSB-o	nlv	
-	amounts describe the Enrollee's out of pocket costs.	Silver	• *	
		HDHP P		
Actuarial Value - A\		71.3% <u>71.</u>		
	Plan design includes a deductible? Integrated Individual deductible	Yes, integr \$2,500 integ		
	Integrated Family deductible	\$5,000 integ		
	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		
	Family Out-of-pocket maximum	\$13,700		
	HSA plan: Self-only coverage deductible	\$2,500		
	HSA family plan: Individual deductible	See endr	lote	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care	Primary care visit to treat an injury, illness, or condition	20%	x	
provider's office or	Other practitioner office visit	20%	x	
clinic visit	Specialist visit	20%	X	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	20%	X	
Tests	X-rays and Diagnostic Imaging	20%	Х	
	Imaging (CT/PET scans, MRIs)	20%	Х	
	Tier 1	20% up to \$250 per script	X	
Drugs to treat	Tier 2	20% up to \$250 per script	x	
condition	Tier 3	20% up to \$250 per script	x	
	Tier 4	20% up to \$250 per script	х	
	Surgery facility fee (e.g., ASC)	20%	X	
Outpatient services	Physician/surgeon fees	20%	X	
	Outpatient visit	20%	Х	
	Emergency room facility fee (waived if admitted)	20%	Х	
Need immediate	Emergency room physician fee (waived if admitted)	0%	Х	
attention	Medical transportation (including emergency and non-emergency)	20%	Х	
	Urgent care	20%	Х	
	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%	x	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	x	
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	,	
	Home health care (cost share per visit)	20%	X	
Help recovering or	Outpatient Rehabilitation and Habilitation services	20%	X	
other special	Skilled nursing care	20%	X	
health 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	Not Covered		
and Preventive	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services			
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	Not Covered		
	Prosthodontics			
Ohiid	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics	Not Covered		

ember Cost Share amounts describe the Enrollee's out of pocket costs.		Silver P 100%-1509		Silver Plan 150%-200% FPL		
tuarial Value - A\	/ Calculator	94.5% <u>94</u>		87.7%87.9%		
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pharma	асу	
	Integrated Individual deductible	N/A		N/A		
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$1,400 / \$100 / \$0)	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$2,800 / \$200 / \$0)	
	Individual Out–of–pocket maximum	\$1,000		\$ 2,700 \$2,750		
	Family Out-of-pocket maximum	\$2,000)	\$ 5,400 \$ <u>5,500</u>		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A		
Common		Member Cost	Deductible		Deductib	
Medical Event	Service Type	Share	Applies	Member Cost Share	Applies	
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
provider's	Other practitioner office visit	\$5		\$15		
office or clinic visit	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	·				
	Laboratory Tests	No charge \$8		No charge \$20		
Tests	X-rays and Diagnostic Imaging	\$8		\$40		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
	Tier 1	\$3		\$5 <u>\$10</u>	Dt.	
orugs to treat	Tier 2	\$10		\$25	Pharma deducti	
ondition	Tier 3	\$15		\$45	Pharma deducti	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharma deducti	
	Surgery facility fee (e.g., ASC)	10%		15%		
Outpatient services	Physician/surgeon fees	10%		15%		
ei vices	Outpatient visit	10%		15%		
	Emergency room facility fee (waived if admitted)	\$50		\$150\$175		
leed	Emergency room physician fee (waived if admitted)	No charge		No charge		
immediate attention	Medical transportation (including emergency and non-emergency)	\$30		\$75		
	Urgent care					
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	\$5		\$15		
lospital stay	delivery, mental health, and substance use)	10%	X	15%	Х	
	Physician/surgeon fee	10%		15%		
Mental health, behavioral nealth, or	Mental/behavioral health and substance use disorder outpatient office 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		
lala.	Outpatient Rehabilitation and Habilitation services	\$5 \$5		\$15		
lelp ecovering or	·	·				
ther special	Skilled nursing care	10%	Х	15%	Х	
.cuiti. Hodus	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
nd	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered		
el vices						
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	Not Covered		Not Covered		

20202021 Patient-Centered Benefit Plan Designs 9.5 EHB Date: May 16, 2019 January 16, 2020

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
tuarial Value - A\	√ Calculator	73.9% 73.6%	
	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	\$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 HSA plan: Self-only coverage deductible	\$13,000 N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	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	Pharma
Drugs to treat	Tier 2	\$55	deductik Pharma
illness or condition	Tier 3	\$85	deductik Pharma
oonanon		20% up to \$250 per script	deductik Pharma
	Tier 4	after pharmacy deductible	deductik
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	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%	Х
	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 Dowtel	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	NOT COVERED	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Day	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

20202021 Patient-Centered Benefit Plan Designs 9.5 EHB Date: May 16, 2019 January 16, 2020

	2019 January 16, 2020 efits and Coverage				
Member Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	
Actuarial Value - A\	/ Calculator	61.4% <u>64.85%</u>		62.1% <u>64.6</u>	<u>6%</u>
	Plan design includes a deductible?	Yes, Medical/Phari	macy	Yes, integra	
	Integrated Individual deductible	N/A N/A		\$6,900 <u>\$7,000</u> in	-
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 \$750	/ \$0	\$13,800 <u>\$14,000</u> i	integrated
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / <mark>\$1,000\$1,5</mark>		N/A	
	Individual Out-of-pocket maximum	\$ 7,800 \$ 7,950		See endno	ote
	Family Out-of-pocket maximum	\$15,600 <u>\$15,90</u>	<u>0</u>	See endno	ote
	HSA plan: Self-only coverage deductible	N/A		\$ 6,900 \$7,0	000
	HSA family plan: Individual deductible	N/A		\$6,900 <u>\$7.0</u>	<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 \$85	After 1st three non- preventive visits	0%	Х
Health care provider's	Other practitioner office visit	\$ 65 \$85	After 1st three non-	0%	X
office or	·		preventive visits After 1st three non-		
clinic visit	Specialist visit	\$95 <u>\$115</u>	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge	V	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 40%	<u>X</u> X	0% 0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	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%	х
illness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	X
		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy		
	Tier 4	pharmacy deductible	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%	Х
	Urgent care	\$65 <u>\$85</u>	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%	×	0%	Х
Hospital stay	Physician/surgeon fee	40%	×	0%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-		
behavioral	visits	\$ 65 \$85	preventive visits	0%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient	********	X	0%	X
abuse needs	items and services	\$65 <u>\$85</u>	^		^
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	X	0%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$ 65 \$85		0%	X
other special	Skilled nursing care	40%	X	0%	Х
health needs	Durable medical equipment	40%	X	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				
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 Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
OCI VICES	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics	Not Covered		1101 Govereu	
	Oral Surgery				
Child		N . 2		N 10 :	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

•	nefits and Coverage	2.	trombie Die
	amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan
tuarial Value - A\	V Calculator		
	Plan design includes a deductible?		integrated
	Integrated Individual deductible		3,300 integrated
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 10,300 <u>\$ 1</u>	6,600 integrated
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	\$8.2	1 50 \$8,300
	Family Out-of-pocket maximum		300 <u>\$16,600</u>
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no
Health care provider's	Other practitioner office visit	0%	After 1st three no
office or clinic visit	Specialist visit	0%	X
			^
	Preventive care/ screening/ immunization	No charge 0%	X
Tests	Laboratory Tests X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
Drugs to treat illness or	Tier 2	0%	X
condition	Tier 3	0%	X
	Tier 4	0%	X
0.4	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%	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 n
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	×
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three n
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	0%	X
other special health needs	Skilled nursing care	0%	X
neaith needs	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	Not Covered	
. revenuve	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
JUI 11005	Crowns and Casts		
Child Dental	Endodontics	N-4-0	
Major			
Major Services	Periodontics (other than maintenance) Prosthodontics	Not Covered	

Medically necessary orthodontics

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.
	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;
	Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	Drugs that are biologics and drugs that the Food and
	Drug Administration (FDA) or drug manufacturer requires to
	be distributed through specialty pharmacies;
4	2) Drugs that require the enrollee to have special training or
4	clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than
	six hundred dollars (\$600) net of rebates for a one-month
	supply.

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 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.