Covered California 2018 Patient-Centered Benefit Plan Designs¹

Final Board-approved June 15, 2017²

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

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

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



Member Cost Si	hare amounts describe the En	rollee's out of pocket costs.	Platinu Coinsurand		Platinu Copay F	
	e - AV Calculator		91.29	6	88.1%	0
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible		\$0		\$0	
Individual ded	ductible, NOT integrated: Metible, NOT integrated: Medic	edical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
ndividual Out-	-of-pocket maximum	arr marmady r bornar	\$3,35	0	\$3,35	0
amily Out-of-p	pocket maximum -only coverage deductible		\$6,70 N/A	0	\$6,70 N/A	0
ISA family pla	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an i	njury, illness, or condition	\$15		\$15	
ffice or clinic	Other practitioner office visit		\$15		\$15	
isit	Specialist visit		\$30		\$30	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imagin	q	\$15 \$30		\$15 \$30	
	Imaging (CT/PET scans, MRI		10%		\$75	
	Tier 1		\$5		\$5	
Orugs to treat	Tier 2		\$15		\$15	
am attatam	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	1	10%		\$100 \$25	
ervices	Outpatient visit		10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
Need	Emergency medical transport	ation	\$150		\$150	
ttention	Urgent care		\$15		\$15	
		,			\$250 per day up	
iospitai stay	Facility fee (e.g. hospital roon	1)	10%		to 5 days	
	Physician/surgeon fee Mental/Behavioral health outpatient office visits		10% \$15		No charge \$15	
	Mental/Behavioral health other	er outpatient items and services	\$15		\$15	
	Mental/Rehavioral health inna	tient facility fee (e.g.hospital room)	10%		\$250 per day up	
lental health,					to 5 days	
ehavioral ealth, or	Mental/Behavioral health inpa	tient physician fee	10%		No charge	
ubstance	Substance Use disorder outp	atient office visits	\$15		\$15	
	Substance Use disorder othe	r outpatient items and services	\$15		\$15	
	Substance Use inpatient facil	ty fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpat	ient physician fee	10%		No charge	
	Prenatal care and preconcept		No charge		No charge	
	Delivery and all inpatient	Hospital	10%		\$250 per day up	
	services	Professional	10%		to 5 days No charge	
	Home health care (cost share	per visit)	10%		\$20	
ieip	Outpatient Rehabilitation service Outpatient Habilitation service		\$15 \$15		\$15 \$15	
ecovering or	Skilled nursing care		10%		\$150 per day up	
palth needs	Durable medical equipment		10%		to 5 days 10%	
	Hospice service		No charge		No charge	
hild eye care	Eye exam	contact laneae in lieu of al'	No charge		No charge	
	1 pair of glasses per year (or Oral Exam	contact renses in neu or grasses)	No charge		No charge	
hild Dental	Preventive - Cleaning					
iagnostic nd	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
iasic iervices	Restorative Procedures Periodontal Maintenance Ser	vices	20%		See 2018 Dental Copay Schedule	
	Crowns and Casts Endodontics					
niid Dentai		tenance)	50%		See 2018 Dental	
Services	Periodontics (other than main Prosthodontics Oral Surgery	тепено с)	JU76		Copay Schedule	
bild	Medically necessary orthodor	ntics	50%		\$1,000	

Member Cost S	Benefits and Coverage hare amounts describe the Enre e - AV Calculator	ollee's out of pocket costs.	Gold Coinsuran 81.89	ce Plan	Gold Copay F 78.4%	lan
Plan design in	cludes a deductible?		No		No	
	dividual deductible		\$0 \$0		\$0 \$0	
Individual de	ductible, NOT integrated: Me		\$0 / \$0		\$0 / \$0 /	
	ctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$0 / \$0 \$6,00		\$0 / \$0 / \$6,00	
Family Out-of-	pocket maximum		\$12,0		\$12,00	
HSA plan: Self-	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
riox raininy pia	III. IIIdividdai deddetible		1975		10/4	
Common Medical Event	Se	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	jury, illness, or condition	\$25		\$25	
Health care provider's office or clinic visit	Other practitioner office visit		\$25		\$25	
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in Laboratory Tests	munization	No charge \$35		No charge \$35	
Tests	X-rays and Diagnostic Imaging		\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1		\$15		\$15	
Dutpatient	Tier 2		\$55		\$55	
	Tier 3		\$75		\$75	
	Tier 4 Surgery facility fee (e.g., ASC)		20% up to \$250 per script 20%		20% up to \$250 per script \$300	
Outpatient	Physician/surgeon fees		20%		\$300 \$40	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (v	vaived if admitted)	\$325		\$325	
	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transporta		\$250		\$250	
attention	Urgent care		\$25		\$25	
					\$600 per day up	
Hospital stay	Facility fee (e.g. hospital room)	20%		to 5 days	
	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health outpatient office visits		\$25		\$25	
	Mental/Behavioral health othe	outpatient items and services	\$25		\$25	
	Mental/Behavioral health inpa	ient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
Mental health,	Mental/Behavioral health inpa	ient nhysician fee	20%		No charge	
behavioral health, or substance abuse needs	Substance Use disorder outpa		\$25		\$25	
	Substance Use disorder other	outpatient items and services	\$25		\$25	

	Substance Use inpatient facili		20%		\$600 per day up to 5 days	
	Substance use disorder inpati		20% No charge		No charge	
Pregnancy	Prenatal care and preconcept Delivery and all inpatient	Hospital			\$600 per day up	
	services	,	20%		to 5 days	
	Home health care (cost share		20%		No charge \$30	
Help	Outpatient Rehabilitation serv	ces	\$25		\$25	
recovering or	Outpatient Habilitation service	5	\$25		\$25 \$300 per day up	
other special health needs	Skilled nursing care Durable medical equipment		20%		to 5 days 20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
- Cys care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning		1			
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge	
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		20%		See 2018 Dental	
Services	Periodontal Maintenance Serv	ices			Copay Schedule	
	Crowns and Casts Endodontics					
Child Dental		enance)	E00/		See 2018 Dental	
Major Services	Prosthodontics Oral Current	onantoe)	50%		Copay Schedule	
Child	Oral Surgery					
Child Orthodontics	Medically necessary orthodon	ics	50%		\$1,000	

	15, 2017			
	Benefits and Coverage		Individua	
	hare amounts describe the Er	nrollee's out of pocket costs.	Silver Plan	1
	e - AV Calculator		71.9%	
Integrated Inc	cludes a deductible? dividual deductible		Yes, Medical/Pha N/A	armacy
	mily deductible ductible, NOT integrated: M	ledical / Pharmacy / Dental	N/A \$2,500 / \$130	/\$0
Family deduc	tible, NOT integrated: Medi		\$5,000 / \$260	
Family Out-of-	-of-pocket maximum pocket maximum		\$7,000 \$14,000	
HSA plan: Self-	only coverage deductible n: Individual deductible		N/A N/A	
northanny pia	iii iiidiridaal acaaciibic		1471	
Common				Deductible
Medical Event	S	ervice Type	Member Cost Share	Applies
	Primary care visit to treat an	injury, illness, or condition	\$35	
Health care				
orovider's office or clinic	Other practitioner office visit		\$35	
visit				
	Specialist visit		\$75	
	Preventive care/ screening/ i	mmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	20	\$35 \$75	
1 6313	Imaging (CT/PET scans, MR		\$300	
	Tier 1		\$15	Pharmacy
				deductible
Drugs to treat	Tier 2		\$55	Pharmacy deductible
liness or				
condition	Tier 3		\$80	Pharmacy deductible
	T		20% up to \$250 per	Pharmacv
	Tier 4		script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	C)	20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee	(waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)		No charge	
Need immediate	Emergency medical transpor	tation	\$250	Х
attention				
	Urgent care		\$35	
Hospital stay	Facility fee (e.g. hospital roor	m)	20%	X
	Physician/surgeon fee		20%	
	Mental/Behavioral health out	patient office visits	\$35	
	Mental/Behavioral health other outpatient items and services		\$35	
Mental health,	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х
behavioral	Mental/Behavioral health inpa	atient physician fee	20%	Х
health, or substance				
abuse needs	Substance Use disorder outp	patient office visits	\$35	
	Substance Use disorder other	er outpatient items and services	\$35	
	Substance Use inpatient faci	lity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpa	tient physician fee	20%	х
	Prenatal care and preconcep	otion visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care (cost share	Professional e per visit)	20% \$45	X
Help	Outpatient Rehabilitation ser	vices	\$35	
recovering or other special	Outpatient Habilitation service Skilled nursing care	003	\$35 20%	×
nealth needs	Durable medical equipment		20%	^
	Hospice service		No charge No charge	
Child eye care	Eye exam 1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge No charge	
	Oral Exam		Indigo	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and Preventive	Sealants per Tooth		No charge	
	Topical Fluoride Application Space Maintainers - Fixed			
rieveillive	Restorative Procedures		20%	
Child Dental		rvices	20%	
Child Dental Basic	Periodontal Maintenance Ser			
Child Dental Basic Services	Crowns and Casts			
Child Dental Basic Services Child Dental		ntenance)	50%	
Child Dental Basic Services Child Dental Major	Crowns and Casts Endodontics Periodontics (other than main Prosthodontics	ntenance)	50%	
Child Dental Basic Services Child Dental Major Services Child	Crowns and Casts Endodontics Periodontics (other than main	ntenance)	50%	

			2000		0000	
Summary of	Benefits and Coverage		CCSB Silver		CCSB Silver	
	hare amounts describe the En	rollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	n
	- AV Calculator		71.9%		71.4%	
	cludes a deductible?		Yes, Medical/Ph N/A	armacy	Yes, Medical/Pha N/A	armacy
Integrated Fa	mily deductible		N/A		N/A	
	ductible, NOT integrated: Me tible, NOT integrated: Medic		\$2,000 / \$125 \$4,000 / \$250		\$2,000/ \$125 \$4,000 / \$250	
Individual Out-	-of-pocket maximum	ar / Framacy / Dentar	\$7,000	7 40	\$7,000	7 40
	pocket maximum -only coverage deductible		\$14,000 N/A		\$14,000 N/A	
	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an in	njury, illness, or condition	\$45		\$45	
Health care provider's office or clinic	Other practitioner office visit		\$45		\$45	
/ISIT	Specialist visit		\$75		\$75	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imagin	0	\$40 \$70		\$40 \$70	
	Imaging (CT/PET scans, MRI:		20%		\$300	
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmac deductibl
dember Cost Shaketuarial Value - Plan design includintegrated Individual deduction of the property of the prop	Tier 2		\$55	Pharmacy deductible	\$55	Pharmac deductibl
	Tier 3		\$85	Pharmacy deductible	\$85	Pharmac deductibl
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy deductible	20% up to \$250 per script after pharmacy	Pharmac deductibl
Outpations	Surgery facility fee (e.g., ASC)	deductible 20%		deductible 20%	
services	Physician/surgeon fees Outpatient visit		20%		20%	
		unived if admitted	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Dutpatient Services Control Co	Emergency room physician fe		No charge		No charge	
	Emergency medical transport	ation	\$250	Х	\$250	Х
	Urgent care		\$45		\$45	
Hoenital etay	Facility fee (e.g. hospital room	1)	20%	Х	20%	Х
nospitai stay	Physician/surgeon fee		20%	Х	20%	Х
	Mental/Behavioral health outp	patient office visits	\$45		\$45	
	Mental/Behavioral health other	er outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х	20%	Х
Mental health,						
health, or substance	Mental/Behavioral health inpa Substance Use disorder outpa		20%	Х	20%	X
abuse needs						
	Substance Use disorder other	r outpatient items and services	\$45		\$45	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х	20%	Х
	Substance use disorder inpat	ient physician fee	20%	х	20%	х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	20%	Х
	services	Professional	20%	Х	20%	Х
	Home health care (cost share Outpatient Rehabilitation serv		20% \$45		\$45 \$45	
Help recovering or	Outpatient Renabilitation service		\$45 \$45		\$45 \$45	
other special	Skilled nursing care		20%	х	20%	Х
health needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of placeae)	No charge		No charge	
	Oral Exam	ornado renego in ilea Ol Glasses)	ino charge		rvo charge	
	Preventive - Cleaning					
	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental	Space Maintainers - Fixed				0. 000 -	
Basic Services	Restorative Procedures Periodontal Maintenance Sen	vices	20%		See 2018 Dental Copay Schedule	
	Crowns and Casts					
Child Dental	Endodontics				See 2018 Dental Copay	
Major Services	Periodontics (other than main Prosthodontics	tenance)	50%		Schedule	
	Oral Surgery					
Child	Medically necessary orthodor	itics	50%		\$1,000	
Orthodontics	Liberry moodsaary orandedi		3076		ψ1,000	

Summary of	Benefits and Coverage		CCSE	
	hare amounts describe the Enr	ollee's out of pocket costs.	Silver HDHP P	lan
	e - AV Calculator		71.7%	
	cludes a deductible? dividual deductible		Yes, integr \$2,000 integr	
Integrated Fa	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$4,000 integ N/A	grated
Family deduc	ctible, NOT integrated: Medic		N/A \$6,550)
Family Out-of-	pocket maximum		\$13,10	0
	only coverage deductible n: Individual deductible		\$2,000 \$2,700	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	20%	x
Health care provider's office or clinic	Other practitioner office visit		20%	х
visit	Specialist visit		20%	х
	Preventive care/ screening/ im	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		20% 20%	X
	Imaging (CT/PET scans, MRIs		20%	X
	Tier 1		20% up to \$250 per script	х
Drugs to treat	Tier 2		20% up to \$250 per script	х
condition	Tier 3		20% up to \$250 per script	х
	Tier 4		20% up to \$250 per script	х
Outpatient	Surgery facility fee (e.g., ASC)		20%	X
services	Physician/surgeon fees Outpatient visit		20%	X
	Emergency room facility fee (w	raived if admitted)	20%	X
	Emergency room physician fee	(waived if admitted)	0%	х
immediate	Emergency medical transporta	tion	20%	Х
Outpatent Services Or Services	Urgent care		20%	х
	Facility fee (e.g. hospital room)		20%	×
Hospital Stay	Physician/surgeon fee		20%	X
поѕрітаї ѕтау	Mental/Behavioral health outpatient office visits		20%	Х
	Mental/Behavioral health other outpatient items and services		20%	х
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	20%	×
health, or substance				
abuse needs	Substance Use disorder outpa	tient office visits	20%	Х
	Substance Use disorder other	outpatient items and services	20%	х
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatie	ent physician fee	20%	Х
	Prenatal care and preconcepti	on visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care (cost share	Professional per visit)	20%	X X
Help	Outpatient Rehabilitation servi	ces	20%	X
recovering or	Outpatient Habilitation services	S	20%	X
other special health needs	Skilled nursing care		20%	X
	Durable medical equipment Hospice service		20%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or o Oral Exam	ontact lenses in lieu of glasses)	No charge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Serv	ices	20%	
	Crowns and Casts			
Child Dental	Periodontics (other than maint	ananca)	50%	
Major Services	Prosthodontics (other than maint	onanos)	50%	
	Oral Surgery			
Child Orthodontics	Medically necessary orthodon	ics	50%	

Summary	of Ben	efits and	Coverage

Summary of	Benefits and Coverage		Silver F	llan	Silver Plan	
	hare amounts describe the Enr	ollee's out of pocket costs.	100%-150	% FPL	150%-200% F	
	e - AV Calculator		93.99		88.0%	
Integrated In	cludes a deductible? dividual deductible		Yes, Medical/ N/A		Yes, Medical/Pha N/A	rmacy
	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	N/A \$75 / \$0		N/A \$650 / \$50 / \$	60
Family deduc	ctible, NOT integrated: Medic		\$150 / \$0 \$1,00	0/\$0	\$1,300 / \$100 / \$2,450	
Family Out-of-	pocket maximum		\$2,00	10	\$4,900	
HSA plan: Self HSA family pla	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in		\$5		\$10	
Health care provider's office or clinic	Other practitioner office visit		\$5		\$10	
visit	Specialist visit		\$8		\$25	
	Preventive care/ screening/ im	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	\$8 \$8		\$15 \$25	
	Imaging (CT/PET scans, MRIs		\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat illness or	Tier 2		\$10		\$20	Pharmacy deductible
condition	Tier 3		\$15		\$35	Pharmacy deductible
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC) Physician/surgeon fees		10%		15% 15%	
services	Outpatient visit		10%		15%	
	Emergency room facility fee (v	vaived if admitted)	\$50		\$100	
Need	Emergency room physician fee		No charge		No charge	
immediate	Emergency medical transporta	ation	\$30	Х	\$75	Х
attention	Urgent care		\$5		\$10	
	Facility fee (e.g. hospital room)	10%	X	15%	Х
Hospital stay	Physician/surgeon fee	<u>′</u>	10%	Х	15%	Х
	Mental/Behavioral health outpatient office visits		\$5		\$10	
	Mental/Behavioral health other	r outpatient items and services	\$5		\$10	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	10%	×	15%	Х
Mental health,	Mental/Behavioral health inpat		10%	X	15%	X
behavioral health, or substance abuse needs	Substance Use disorder outpa	.,	\$5	^	\$10	^
	Substance Use disorder other	outpatient items and services	\$5		\$10	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%	Х	15%	Х
	Substance use disorder inpatie		10%	×	15%	х
	Prenatal care and preconcepti		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	х
	services	Professional	10%	X	15%	Х
Help	Home health care (cost share Outpatient Rehabilitation servi		\$3 \$5		\$15 \$10	
Help recovering or	Outpatient Habilitation service	S	\$5		\$10	
other special health needs	Skilled nursing care		10%	Х	15%	Х
	Durable medical equipment Hospice service		10% No charge		15% No charge	
Child eye care	Eye exam		No charge		No charge	
o.ma cye care	1 pair of glasses per year (or c Oral Exam	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures		20%		20%	
Services	Periodontal Maintenance Serv Crowns and Casts	ices				
Child Dental	Endodontics					
Major Services	Periodontics (other than maint	enance)	50%		50%	
Col VICES	Prosthodontics Oral Surgery		1			
Child	Medically necessary orthodon	tics	500/		500/	
Orthodontics	modically fieldssally offillodoff		50%		50%	

2018 Patient-Centered Benefit Plan Designs 10.0 EHB

Member Cost S	hare amounts describe the E	nrollee's out of pocket costs.	Silver Plan	
	- AV Calculator	nonce a out of pocket coats.	200%-250% FP 73.9%	L
	cludes a deductible?		Yes, Medical/Phari	macy
Integrated Inc	dividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: N	edical / Pharmacy / Dental	\$2,200 / \$130 / \$	
	tible, NOT integrated: Medi -of-pocket maximum	cai / Pharmacy / Dentai	\$4,400 / \$260 / \$ \$5,850	ÞU
Family Out-of-p	oocket maximum		\$11,700 N/A	
HSA family pla	only coverage deductible n: Individual deductible		N/A	
Common Medical Event	٠	oruico Tuno	Member Cost Share	Deductib Applies
inculcal Event	Primary care visit to treat an	ervice Type injury, illness, or condition	\$30	жириес
Health care provider's	Other practitioner office visit		\$30	
office or clinic visit	Specialist visit		\$75	
	Preventive care/ screening/	mmunization	No charge	
	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imaging (CT/PET scans, MR	ng Is)	\$75 \$300	
	Tier 1	,	\$15	Pharma deductib
Drugs to treat	Tier 2		\$50	Pharma
illness or condition	Tier 3		\$75	Pharma
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharma
	Surgery facility fee (e.g., AS	C)	20%	deduciii
Outpatient services	Physician/surgeon fees	,	20%	
	Outpatient visit	Construct Mandaghtan B	20%	
	Emergency room facility fee		\$350	
Need	Emergency room physician f	· · · · · · · · · · · · · · · · · · ·	No charge	
immediate attention	Emergency medical transpor	tation	\$250	Х
attention	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital room	m)	20%	Х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health out	patient office visits	\$30	
	Mental/Behavioral health oth	er outpatient items and services	\$30	
	Mental/Behavioral health inp	atient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inp	atient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder out	patient office visits	\$30	
	Substance Use disorder other	er outpatient items and services	\$30	
	Substance Use inpatient faci	lity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpa	tient physician fee	20%	Х
	Prenatal care and preconcep		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care (cost shar	Professional e per visit)	20% \$40	Х
Help	Outpatient Rehabilitation ser	vices	\$30	
recovering or other special	Outpatient Habilitation service Skilled nursing care	cs	\$30 20%	Х
health needs	Durable medical equipment		20%	^
	Hospice service		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge No charge	
	Oral Exam	oomaat renaes in red Ut glasses)	ino criarge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		20%	
Services	Periodontal Maintenance Se	rvices		
Child Dental	Crowns and Casts Endodontics			
Major	Periodontics (other than mail	ntenance)	50%	
Services	Prosthodontics Oral Surgery			
	ourgory			

Medically necessary orthodontics

50%

	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	Bronz HDHP P 61.4%	lan
	cludes a deductible?	Yes, Medical/Pha	ırmacy	Yes, integ	
Integrated In	dividual deductible	N/A		\$4,800 inte	
Individual de	amily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$6,300 / \$500	/\$0	\$9,600 inte N/A	grated
	ctible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,00 \$7,000	0/\$0	N/A \$6,55	n
amily Out-of-	pocket maximum	\$14,000		\$13,10	0
HSA plan: Self	-only coverage deductible In: Individual deductible	N/A N/A		\$4,80 \$4,80	
71					
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	Х
Health care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	х
visit	Specialist visit	\$105	After 1st three non-preventive visits	40%	Х
	Preventive care/ screening/ immunization	No charge	VIORO	No charge	
	Laboratory Tests	\$40		40%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	100%	X	40% 40%	X
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
illness or condition	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500	Х
	Surgery facility fee (e.g., ASC)	after pharmacy deductible	Deductible	per script	X
Outpatient services	Physician/surgeon fees	100%	X	40%	X
services	Outpatient visit	100%	X	40%	Х
	Emergency room facility fee (waived if admitted)	100%	X	40%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need mmediate	Emergency medical transportation	100%	X	40%	Х
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)	100%	×	40%	×
	Physician/surgeon fee	100%	X	40%	Х
	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health other outpatient items and services	\$75	х	40%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	Х
Mental health,	Montal/Rehavioral health innations obvision for	100%	X	40%	×
behavioral health, or	Mental/Behavioral health inpatient physician fee	100%	X	40%	
substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	х
	Substance Use disorder other outpatient items and services	\$75	х	40%	х
	Substance Use inpatient facility fee (e.g. hospital room)	100%	Х	40%	Х
	Substance use disorder inpatient physician fee	100%	Х	40%	х
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	100%	Х	40%	х
	services Professional	100%	X	40%	X
	Home health care (cost share per visit)	100%	X	40%	X
-lelp	Outpatient Rehabilitation services Outpatient Habilitation services	\$75 \$75		40% 40%	X
recovering or other special	Skilled nursing care	100%	Х	40%	X
nealth needs	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
o, o care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application	,		Ĭ	
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics Oral Surgery				
Child		E00/		E00/	
Child Orthodontics	Medically necessary orthodontics	50%		50%	

	nare amounts describe the Enr	onee's out or pocket costs.	Catastro	phic Plan
	cludes a deductible?		Yes, int	egrated
Integrated Inc	lividual deductible		\$7,350 ir	ntegrated
Integrated Fa Individual de	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental		ntegrated /A
Family deduc	tible, NOT integrated: Medic	al / Pharmacy / Dental	N	/A
	of-pocket maximum oocket maximum		\$7, \$14	350 ,700
	only coverage deductible		N	
noa iaiiiiy pia	n: Individual deductible		N	A
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	0%	After 1st three non-preventive visits
Health care provider's office or clinic	Other practitioner office visit		0%	After 1st three non-preventive visits
visit	Specialist visit		0%	х
	Preventive care/ screening/ im	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	<u> </u>	0% 0%	X
	Imaging (CT/PET scans, MRIs		0%	X
	Tier 1		0%	Х
Drugs to treat	Tier 2		0%	х
condition	Tier 3		0%	х
	Tier 4		0%	х
Outpatient	Surgery facility fee (e.g., ASC)		0%	X
services	Physician/surgeon fees Outpatient visit		0%	X
	Emergency room facility fee (w	vaived if admitted)	0%	X
	, , ,	,		
Need	Emergency room physician fee Emergency medical transporta		No charge 0%	X
mmediate attention		ilion		After 1st three
	Urgent care		0%	non-preventive visits
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee)	0%	X
	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	х
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	0%	x
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	0%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	х
	Substance Use inpatient facilit	y fee (e.g. hospital room)	0%	Х
	Substance use disorder inpatie	ent physician fee	0%	х
	Prenatal care and preconcepti		No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	Х
	services	Professional	0%	Х
	Home health care (cost share		0% 0%	X
Help recovering or	Outpatient Rehabilitation servi Outpatient Habilitation service:		0%	X
other special	Skilled nursing care		0%	х
health needs	Durable medical equipment		0%	Х
	Hospice service Eye exam		0% No charge	X
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	0%	Х
	Oral Exam		3,0	
	Preventive - Cleaning			
and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental	Restorative Procedures		00/	×
Basic Services	Periodontal Maintenance Serv	ices	0%	X
	Crowns and Casts			X
Child Dental	Endodontics	,		X
Major Services	Periodontics (other than maint	enance)	0%	Х
	Prosthodontics Oral Surgery		1	X
Child				
Orthodontics	Medically necessary orthodont	IICS	0%	Х



•	Benefits and Coverage		Platinu	ım	Platinu	m
	hare amounts describe the Er	rollee's out of pocket costs.	Coinsurand	ce Plan	Copay F	lan
	e - AV Calculator		91.29 No	6	88.19 No	5
Integrated In	cludes a deductible? dividual deductible		\$0		\$0	
Integrated Fa Individual de	ımily deductible ductible, NOT integrated: M	edical / Pharmacy / Dental	\$0 \$0 / \$0 /	\$0	\$0 \$0 / \$0 /	\$0
Family deduc	ctible, NOT integrated: Medi -of-pocket maximum		\$0 / \$0 / \$3,35	\$0	\$0 / \$0 / \$3,35	\$0
Family Out-of-	pocket maximum		\$6,70		\$6,70	
	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
71						
Common Medical Event		ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
medical Event			Onare	Applies	Onare	Дрриез
	Primary care visit to treat an	njury, illness, or condition	\$15		\$15	
Health care						
provider's office or clinic	Other practitioner office visit		\$15		\$15	
visit						
	Specialist visit		\$30		\$30	
	Preventive care/ screening/ i	mmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ıg	\$15 \$30		\$15 \$30	
	Imaging (CT/PET scans, MR	s)	10%		\$75	
	Tier 1		\$5		\$5	
Drugs to treat	Tier 2		\$15		\$15	
illness or condition	Tier 3		\$25		\$25	
	0					
	Tier 4	10% up to \$250 per script		10% up to \$250 per script		
	Surgery facility fee (e.g., ASC	;)	10%		\$100	
Outpatient services	Physician/surgeon fees		10%		\$25	
	Outpatient visit		10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need	Emergency room physician for	* * * * * * * * * * * * * * * * * * * *	No charge		No charge	
immediate	Emergency medical transport	ation	\$150		\$150	
attention	Urgent care		\$15		\$15	
	organi dara		Ψ13		Ψ15	
	Facility fee (e.g. hospital roor	n)	10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days No charge	
	Mantal/Rehavioral health outnations office visits					
	Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services		\$15		\$15	
			\$15		\$15	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	10%		\$250 per day up	
Mental health, behavioral	Mental/Behavioral health inpa	atient physician fee	10%		to 5 days No charge	
health, or			1477			
substance abuse needs	Substance Use disorder outp	atient office visits	\$15		\$15	
	Substance Use disorder other	r outpatient items and services	\$15		\$15	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpar	ient physician fee	10%		No charge	
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services	Professional	10%		No charge	
	Home health care (cost share Outpatient Rehabilitation sen		10% \$15		\$20 \$15	
Help recovering or	Outpatient Habilitation service		\$15		\$15	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care		contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Ser	vices				
Child Dental	Crowns and Casts Endodontics				Not Covered Not Covered	
Major	Periodontics (other than mair	itenance)	Not Covered		Not Covered	
Services	Prosthodontics Oral Surgery				Not Covered Not Covered	
Child			No. C			
Orthodontics	Medically necessary orthodo	ntics	Not Covered		Not Covered	

	hare amounts describe the Enrollee's out of pocket costs.	Coinsurance	e Plan	Gold Copay P	lan
	- AV Calculator	81.89 No	0	78.4% No	•
	dividual deductible	\$0		\$0	
Integrated Fa	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$0 / \$0 /	'\$0	\$0 \$0 / \$0 /	\$0
Family deduc	tible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 /	\$0
	of-pocket maximum	\$6,00 \$12.00		\$6,000 \$12,00	
ISA plan: Self-	only coverage deductible	N/A	,0	N/A	
ISA family pla	n: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$25		\$25	
Health care provider's office or clinic	Other practitioner office visit	\$25		\$25	
risit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$55		\$35 \$55	_
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
rugs to treat	Tier 2	\$55		\$55	
utpatient irvices	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$300	
ervices	Physician/surgeon fees Outpatient visit	20%		\$40 20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
leed framediate ttention	Emergency room physician fee (waived if admitted) Emergency medical transportation	No charge \$250		No charge \$250	
	Urgent care	\$25		\$25	
to only at a to a	Facility fee (e.g. hospital room)	20%		\$600 per day up	
	Physician/surgeon fee	20%		to 5 days No charge	
	Mental/Behavioral health outpatient office visits	\$25		\$25	
	Mental/Behavioral health other outpatient items and services	\$25		\$25	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,				to 5 days	
ealth, or	Mental/Behavioral health inpatient physician fee	20%		No charge	
abuse needs	Substance Use disorder outpatient office visits	\$25		\$25	
	Substance Use disorder other outpatient items and services	\$25		\$25	
lental health, ehavioral ealth, or ubstance buse needs	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician fee	20%		No charge	
	Prenatal care and preconception visits	No charge		No charge	
regnancy	Delivery and all inpatient Hospital	20%		\$600 per day up to 5 days	
	services Professional	20%		No charge	
	Home health care (cost share per visit) Outpatient Rehabilitation services	20% \$25		\$30 \$25	
lelp ecovering or	Outpatient Habilitation services	\$25		\$25	
ther special	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service Eye exam	No charge No charge		No charge No charge	_
hild ave care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	Ť			
	Preventive - Cleaning Preventive - X-ray				
nd Preventive	Sealants per Tooth Topical Fluoride Application	Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
	Periodontal Maintenance Services Crowns and Casts			Not Covered	
	Endodontics			Not Covered	
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics			Not Covered	
	Oral Surgery			Not Covered	
Child		Not Covered		Not Covered	

2018 Patient-Centered Benefit Plan Designs 9.5 EHB

Date:	June	15,	2017
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	Benefits and Coverage	rollee's out of pocket costs	Individua Silver Plan	
	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan	1
	- AV Calculator		71.9%	
	cludes a deductible?		Yes, Medical/Pha N/A	armacy
Integrated Fa	mily deductible	d'ant (Diamana (Daniel	N/A	/ #0
Family deduc	ductible, NOT integrated: Metible, NOT integrated: Medic	edical / Pharmacy / Dental	\$2,500/ \$130 \$5,000/ \$260	
ndividual Out-	of-pocket maximum		\$7,000	
	oocket maximum only coverage deductible		\$14,000 N/A	
HSA family pla	n: Individual deductible		N/A	
Common				Deductible
Medical Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an i	njury, illness, or condition	\$35	
office or clinic	Other practitioner office visit		\$35	
visit	Specialist visit		\$75	
	Preventive care/ screening/ in	nmunization	No charge	
	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI:		\$75 \$300	
	Tier 1		\$15	Pharmac
				Pharmac
Drugs to treat Ilness or condition	ess or		\$55	deductibl
- CAULION	Tier 3		\$80 20% up to \$250 per	deductible
	Tier 4		script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC Physician/surgeon fees	,	20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fe	e (waived if admitted)	No charge	
Need mmediate	Emergency medical transport	\$250	Х	
attention	Urgent care		\$35	
	Facility fee (e.g. hospital room	n)	20%	Х
Hospital stay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	eatient office visits	\$35	
	Mental/Behavioral health othe	er outpatient items and services	\$35	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa		20%	Х
nealth, or substance abuse needs	Substance Use disorder outpo		\$35	X
	Substance Lice disorder other	routestiest items and convices	Par	
		r outpatient items and services	\$35	
	Substance Use inpatient facili	ty tee (e.g. hospital room)	20%	Х
	Substance use disorder inpat		20%	Х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care (cost share	Professional per visit)	20% \$45	Х
Help	Outpatient Rehabilitation serv	ices	\$35	
recovering or	Outpatient Habilitation service	es	\$35	
other special nealth needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% No charge	
01.71.4	Eye exam		No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam			
Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		INUI COVERED	
. cvc/inive	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		Not Covered	
Basic Services	Periodontal Maintenance Sen	vices	Not Covered	
	Crowns and Casts			
Child Dental	Endodontics	· · · · · · · · · · · · · · · · · · ·	Net Comment	
Major Services	Periodontics (other than main Prosthodontics	terrance)	Not Covered	
	Oral Surgery			_
Child			Not Covered	

C	Danafita and Causes		0000		2000	
-	Benefits and Covera	=	CCSB Silver		CCSB Silver	
		Enrollee's out of pocket costs.	Coinsurance Plan		Copay Plan	
	e - AV Calculator	71.9% Yes, Medical/Ph	armanı,	71.4% Yes, Medical/Ph	ormoov.	
Integrated Inc	dividual deductible		N/A	armacy	N/A	аппасу
Integrated Fa Individual de	mily deductible ductible, NOT integrated:	N/A \$2,000 / \$125	/ \$0	N/A \$2,000/ \$125	/ \$0	
Family deduc	tible, NOT integrated: Me- -of-pocket maximum	dical / Pharmacy / Dental	\$4,000 / \$250 \$7,000	/\$0	\$4,000 / \$250 \$7,000	/\$0
Family Out-of-	pocket maximum		\$14,000		\$14,000	
	only coverage deductible n: Individual deductible	9	N/A N/A		N/A N/A	
Common Medical Event		Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat a	an injury, illness, or condition	\$45		\$45	
Health care provider's office or clinic visit	Other practitioner office vis	sit	\$45		\$45	
	Specialist visit		\$75		\$75	
	Preventive care/ screening Laboratory Tests	/ immunization	No charge \$40		No charge \$40	
Tests	X-rays and Diagnostic Ima		\$70		\$70	
	Imaging (CT/PET scans, N	IRIs)	20%		\$300	
	Tier 1		\$15	Pharmacy deductible	\$15	Pharmacy deductible
Drugs to treat	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$85	Pharmacy deductible	\$85	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., A Physician/surgeon fees	SC)	20% 20%		20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fe	e (waived if admitted)	\$350		\$350	
	Emergency room physicial	n fee (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transp	ortation	\$250	X	\$250	X
attention	Urgent care		\$45		\$45	
Haarital atau	Facility fee (e.g. hospital ro	oom)	20%	X	20%	X
Hospital stay	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health of	sutpatient office visits	\$45		\$45	
	Mental/Behavioral health of	ther outpatient items and services	\$45		\$45	
	Mental/Behavioral health is	npatient facility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health, behavioral	Mental/Behavioral health in		20%	X	20%	X
health, or substance	Substance Use disorder o		\$45	^	\$45	^
abuse needs			ψ.0		\$10	
	Substance Use disorder o	ther outpatient items and services	\$45		\$45	
		acility fee (e.g. hospital room)	20%	X	20%	X
	Substance use disorder in Prenatal care and precond		20% No charge	Х	20% No charge	×
Pregnancy	Delivery and all inpatient	Hospital	20%	х	No charge	×
- g	services	Professional	20%	X	20%	X
	Home health care (cost sh Outpatient Rehabilitation s	are per visit)	20%		\$45	
Help recovering or	Outpatient Habilitation ser		\$45 \$45		\$45 \$45	
other special	Skilled nursing care		20%	Х	20%	Х
health needs	Durable medical equipmer	t	20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care		or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam					
Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Applicatio	n			2010100	
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance S	Services				
Child Dental	Crowns and Casts Endodontics				Not Covered Not Covered	
Major	Periodontics (other than m	aintenance)	Not Covered		Not Covered	
Services	Prosthodontics				Not Covered	
Child	Oral Surgery				Not Covered	
L-MIIO	Medically necessary ortho	des Per	Not Covered		Not Covered	

Summary of	Benefits and Coverage		CCSE		
Member Cost S	hare amounts describe the Enri	ollee's out of pocket costs.	Silver HDHP Plan		
	e - AV Calculator		71.7%		
	cludes a deductible? dividual deductible		Yes, integrated \$2,000 integrated		
Integrated Fa	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$4,000 integrated N/A		
Family deduc	ctible, NOT integrated: Medica -of-pocket maximum		N/A \$6,550		
Family Out-of-	pocket maximum		\$13,10	0	
	only coverage deductible n: Individual deductible		\$2,000 \$2,700		
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition		20%	х	
Health care provider's office or clinic	Other practitioner office visit		20%	х	
visit	Specialist visit		20%	х	
	Preventive care/ screening/ im	munization	No charge		
Tests	Laboratory Tests		20% 20%	X	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		20%	X	
	Tier 1		20% up to \$250 per script	х	
Drugs to treat	Tier 2		20% up to \$250 per script	х	
illness or condition	Tier 3		20% up to \$250 per script	х	
	Tier 4		20% up to \$250 per script	х	
Outpotions	Surgery facility fee (e.g., ASC)		20%	Х	
Outpatient services	Physician/surgeon fees		20%	X	
	Outpatient visit Emergency room facility fee (w	vaived if admitted)	20%	X	
	Emergency room physician fee		0%	X	
Need immediate	Emergency medical transporta	· · · · · · · · · · · · · · · · · · ·	20%	X	
attention	Urgent care	20%	х		
	Facility fee (e.g. hospital room))	20%	X	
Hospital stay	Physician/surgeon fee	<u>'</u>	20%	Х	
	Mental/Behavioral health outpa	atient office visits	20%	х	
	Mental/Behavioral health other	outpatient items and services	20%	х	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х	
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	20%	Х	
health, or substance abuse needs	Substance Use disorder outpa	tient office visits	20%	х	
	Substance Use disorder other	outpatient items and services	20%	х	
	Substance Use inpatient facility	y fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatie		20%	х	
	Prenatal care and preconception	on visits	No charge		
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х	
	Home health care (cost share	Professional per visit)	20%	X	
Help	Outpatient Rehabilitation servi	ces	20%	X	
recovering or other special	Outpatient Habilitation services	S	20%	X	
other special health needs	Skilled nursing care Durable medical equipment		20%	X	
	Hospice service		0%	X	
Child eye care	Eye exam 1 pair of glasses per year (or or	ontact lenses in lieu of classes)	No charge No charge		
	Oral Exam	J. S. Signosoo,	110 onlinge		
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures		Not Covered		
Services	Periodontal Maintenance Servi	ices			
Child Dental	Crowns and Casts Endodontics				
Major	Periodontics (other than mainte	enance)	Not Covered		
Services	Prosthodontics Oral Surgery				
Child	Medically necessary orthodont	ics	Not Covered		
Orthodontics					

Summary	οf	Renefits	and	Coverage

Summary of	Benefits and Coverage		Silver F	llon	Silver Plan	
	mber Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 100%-150% FPL		150%-200% FPL	
	e - AV Calculator		93.99		88.0%	
	cludes a deductible? dividual deductible		Yes, Medical/ N/A	Pharmacy	Yes, Medical/Pha N/A	rmacy
	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	N/A \$75 / \$0	/\$0	N/A \$650 / \$50 / \$	60
Family deduc	ctible, NOT integrated: Medic		\$150 / \$0 \$1,00)/\$0	\$1,300 / \$100 / \$2,450	
Family Out-of-p	pocket maximum		\$2,00		\$4,900	
HSA plan: Self- HSA family pla	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common			Member Cost	Deductible		Deductible
Medical Event	Ser	vice Type	Share	Applies	Member Cost Share	Applies
	Primary care visit to treat an in	jury, illness, or condition	\$5		\$10	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$10	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ im Laboratory Tests	munization	No charge \$8		No charge \$15	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$8 \$50		\$25 \$100	
	Tier 1)	\$3		\$5	
	Tier 2		\$10		\$20	Pharmacy
illness or			645		#25	deductible
	Tier 3		\$15 10% up to \$150		\$35 15% up to \$150 per	deductible Pharmacy
	Tier 4		per script		script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		10%		15% 15%	
	Outpatient visit		10%		15%	
	Emergency room facility fee (v	vaived if admitted)	\$50		\$100	
Need	Emergency room physician fee	e (waived if admitted)	No charge		No charge	
immediate	Emergency medical transporta	ation	\$30	Х	\$75	Х
attention	Urgent care		\$5		\$10	
Hospital stay	Facility fee (e.g. hospital room)	10%	Х	15%	Х
	Physician/surgeon fee		10%	X	15%	Х
	Mental/Behavioral health outpa	atient office visits	\$5		\$10	
	Mental/Behavioral health other	r outpatient items and services	\$5		\$10	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	10%	Х	15%	х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	10%	х	15%	Х
health, or	Substance Use disorder outpa	tient office visits	\$5		\$10	
	Substance Use disorder other	outpatient items and services	\$5		\$10	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%	Х	15%	х
	Substance use disorder inpatie		10%	Х	15%	Х
	Prenatal care and preconcepti		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	X	15%	X
	Home health care (cost share		10% \$3	X	15% \$15	X
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		\$5 \$5		\$10 \$10	
recovering or	Skilled nursing care		10%	х	15%	х
health needs	Durable medical equipment		10%		15%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application		2010100		2010100	
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Serv Crowns and Casts	ices				
	Endodontics					
	Burgarda artes (albertalis and acceptant	Not Covered		Not Covered		
Sorvinos	Periodontics (other than maint					
Services	Prosthodontics (other than maint Prosthodontics Oral Surgery	·				

Summary	of I	Renefite	and	Coverage

	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan 200%-250% FP	'L
	e - AV Calculator cludes a deductible?		73.9% Yes, Medical/Phari	maay
Integrated In	dividual deductible		N/A	пасу
Integrated Fa Individual de	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	N/A \$2,200 / \$130 / \$	\$0
Family deduc	ctible, NOT integrated: Medic	al / Pharmacy / Dental	\$4,400 / \$260 / \$	
	-of-pocket maximum pocket maximum		\$5,850 \$11,700	
ISA plan: Self	only coverage deductible		N/A	
ISA family pla	n: Individual deductible		N/A	
Common Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	ujury, illness, or condition	\$30	
Health care provider's office or clinic	Other practitioner office visit		\$30	
/isit	Specialist visit		\$75	
	Preventive care/ screening/ in	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	\$35 \$75	
	Imaging (CT/PET scans, MRIs		\$300	
	Tier 1		\$15	Pharmacy deductible
Orugs to treat	Tier 2		\$50	Pharmacy deductible
condition	Tier 3		\$75	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient			20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (v	vaived if admitted)	\$350	
			No shares	
Need	Emergency room physician fer Emergency medical transporta		No charge \$250	Х
mmediate attention	Emergency medical transporta	uion	\$250	^
	Urgent care		\$30	
Hospital stay			20%	Х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits		\$30	
	Mental/Behavioral health othe	\$30		
Mantal Control	Mental/Behavioral health inpar	ient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	20%	Х
nealth, or substance abuse needs	Substance Use disorder outpa	\$30		
	Substance Use disorder other	\$30		
	Substance Use inpatient facilit	v fee (e.g. hospital room)	20%	Х
	Substance use disorder inpati		20%	Х
	Prenatal care and preconcepti		No charge	.,
Pregnancy	Delivery and all inpatient services	Hospital	20%	X
	Home health care (cost share	Professional per visit)	20% \$40	X
lelp	Outpatient Rehabilitation service Outpatient Habilitation service	ces	\$30 \$30	
ecovering or other special	Skilled nursing care	9	\$30 20%	X
nealth needs	Durable medical equipment		20%	^
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
a cyc cale	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		Not Covered	
Services	Periodontal Maintenance Serv	ices	2070.00	
	Crowns and Casts			
Child Dental	Endodontics Regionantics (other than maint	onancol	Not Covered	
Major Services	Periodontics (other than maint Prosthodontics	onante)	Not Covered	
	Oral Surgery			
Child Orthodontics	Medically necessary orthodon	tics	Not Covered	

	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	Bronze HDHP Plan		
	e - AV Calculator	60.8%		61.4%		
	cludes a deductible? dividual deductible	Yes, Medical/Pha N/A	irmacy	Yes, integ \$4,800 inte		
Integrated Fa	mily deductible	N/A	(00	\$9,600 inte		
	ductible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 \$12,600 / \$1,00		N/A N/A		
ndividual Out-	-of-pocket maximum	\$7,000 \$14,000		\$6,55		
	only coverage deductible	\$14,000 N/A		\$13,10 \$4,80		
	n: Individual deductible	N/A		\$4,80	0	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	х	
Health care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	х	
visit	Specialist visit	\$105	After 1st three non-preventive visits	40%	Х	
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$40	V	40%	X	
	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
illness or condition	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
Outpatient	Surgery facility fee (e.g., ASC)	100%	X	40%	Х	
services	Physician/surgeon fees Outpatient visit	100%	X	40% 40%	X	
	Emergency room facility fee (waived if admitted)	100%	X	40%	X	
			^			
Need	Emergency room physician fee (waived if admitted)	No charge		0%	Х	
immediate	Emergency medical transportation	100%	X	40%	Х	
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х	
Hospital stay	Facility fee (e.g. hospital room)	100%	×	40%	×	
	Physician/surgeon fee	100%	X	40%	Х	
	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	Х	
	Mental/Behavioral health other outpatient items and services	\$75	х	40%	х	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	Х	
Mental health,		4000/	V	400/	~	
behavioral health, or	Mental/Behavioral health inpatient physician fee	100%	Х	40%	Х	
substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	х	
	Substance Use disorder other outpatient items and services	\$75	х	40%	х	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	Х	40%	Х	
	Substance use disorder inpatient physician fee	100%	Х	40%	х	
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital	100%	Х	40%	х	
	services Professional	100%	X	40%	X	
	Home health care (cost share per visit)	100%	X	40%	X	
Help .	Outpatient Rehabilitation services Outpatient Habilitation services	\$75 \$75		40% 40%	X	
recovering or	Skilled nursing care	100%	X	40%	X	
hoalth poods	Durable medical equipment	100%	X	40%	X	
	Hospice service	No charge		0%	X	
Child ave ages	Eye exam	No charge		No charge		
	i pair or grasses per year (or contact renses in rieu or grasses)	No charge		No charge		
	Oral Exam Preventive - Cleaning	1				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services		Not Covered		Not Covered		
	Periodontal Maintenance Services Crowns and Casts					
Child Dental	Endodontics	-				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
COI FICES	Prosthodontics Oral Surgery	1				
		·				
Child	Medically necessary orthodontics	Not Covered		Not Covered		

Member Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan			
	e - AV Calculator					
Plan design in	cludes a deductible?		Yes, int	egrated		
Integrated Inc	dividual deductible		\$7,350 ir	itegrated		
Integrated Fa	amily deductible ductible, NOT integrated: Me	edical / Pharmacy / Dental	\$14,700 i			
Family deduc	ctible, NOT integrated: Medic		N.	'A		
Individual Out-	-of-pocket maximum pocket maximum		\$7,: \$14			
HSA plan: Self-	only coverage deductible		N.			
HSA family pla	ın: Individual deductible		N,	'A		
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies		
	Primary care visit to treat an i	njury, illness, or condition	0%	After 1st three non-preventive visits		
Health care provider's office or clinic	Other practitioner office visit		0%	After 1st three non-preventive visits		
visit	Specialist visit		0%	х		
	Preventive care/ screening/ in	nmunization	No charge			
Tanta	Laboratory Tests		0%	Х		
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI:		0%	X		
		<i>5</i> ,				
	Tier 1		0%	Х		
Drugs to treat illness or	Tier 2		0%	Х		
condition	Tier 3		0%	х		
	Tier 4		0%	х		
Outpatient	Surgery facility fee (e.g., ASC	:)	0%	X		
services	Physician/surgeon fees Outpatient visit		0%	X		
		A Company of the American				
	Emergency room facility fee (waiveu ii auriiiteu)	0%	Х		
Need	Emergency room physician fe	e (waived if admitted)	No charge			
immediate	Emergency medical transportation		0%	Х		
attention	Urgent care		0%	After 1st three non-preventive visits		
	Facility fee (e.g. hospital room		0%	Х		
Hospital stay		"				
	Physician/surgeon fee		0%	X		
	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits		
	Mental/Behavioral health othe	0%	х			
Mental health,		tient facility fee (e.g.hospital room)	0%	×		
behavioral	Mental/Behavioral health inpa	itient physician fee	0%	Х		
health, or substance abuse needs	Substance Use disorder outpo	0%	After 1st three non-preventive visits			
	Substance Use disorder other	0%	х			
	Substance Use inpatient facili	ity fee (e.g. hospital room)	0%	Х		
	Substance use disorder inpat	ient physician fee	0%	х		
	Prenatal care and preconcept			^		
Drogram			No charge	V		
Pregnancy	Delivery and all inpatient services	Hospital	0%	X		
	Home health care (cost share	Professional per visit)	0%	X		
Holp	Outpatient Rehabilitation serv		0%	X		
Help recovering or	Outpatient Habilitation service		0%	Х		
other special	Skilled nursing care		0%	Х		
health needs	Durable medical equipment		0%	Х		
	Hospice service		0%	X		
Child eye care	Eye exam	contact languagin Harrard at-	No charge	V		
	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	0%	Х		
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered			
and Preventive	Sealants per Tooth					
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered			
Services	Periodontal Maintenance Sen	vices				
	Crowns and Casts					
	Endodontics					
Child Dental		tenance)	Not Covered			
Major	Periodontics (other than main	,				
Major	Prosthodontics					

Endnotes to Covered California 2018 Patient-Centered Benefit Plan Designs

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

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2,700 for Plan Year 2018. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$200 for a script of up to 30 days per state law (Health and Safety Code § 1397.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.

- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2017 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
2	Any other drugs recommended by the plan's
	pharmaceutical and therapeutics (P&T) committee based on
	drug safety, efficacy and cost.
	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based
3	on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	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.