Covered California 2018 Patient-Centered Benefit Plan Designs¹

Final Draft Board-approved Plan Designs for Discussion

June 15, 2017²-3 January 11, 2018

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

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	hare amounts describe the Enrollee's out of pocket costs.	Platinu		Platinu	
	e - AV Calculator	91.2%91		Copay P 88.1%88	
	cludes a deductible?	No		No	
	dividual deductible mily deductible	\$0 \$0		\$0 \$0	
	ductible, NOT integrated: Medical / Pharmacy / Dental ctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
Individual Out-	-of-pocket maximum	\$3,350)	\$3,350)
	pocket maximum -only coverage deductible	\$6,700 N/A	0	\$6,700 N/A)
HSA family pla	n: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's office or clinic	Other practitioner office visit	\$15		\$15	
visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$15 \$30		\$15 \$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Drugs to treat illness or	Tier 2	\$15		\$15	
condition	Tier 3	\$25		\$25	
	Tier 4 Surgery facility fee (e.g., ASC)	10% up to \$250 per script		10% up to \$250 per script \$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Emergency mMedical transportation (including emergency and non- emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
	Mental/Behavioral health outpatient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	10%		No charge	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatient physician fee	10%		No charge	
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital services	10%		\$250 per day up to 5 days	
	Professional Home health care (cost share per visit)	10% 10%		No charge \$20	
Help	Outpatient Rehabilitation services	\$15		\$15	
recovering or	Outpatient Habilitation services	\$15		\$15 \$150 per day up	
other special health needs	Skilled nursing care	10%		to 5 days	
	Durable medical equipment Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge	
Child Dental Diagnostic	Preventive - Cleaning				
and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge		No charge	
Child Dental	Space Maintainers - Fixed			Soc 20122010	
Basic	Restorative Procedures	20%		See 20182019 Dental Copay	
Services	Periodontal Maintenance Services Crowns and Casts			Schedule	
Child Dental	Endodontics			See 2018 2019	
Major Services	Periodontics (other than maintenance) Prosthodontics	50%		Dental Copay Schedule	
01.11.1	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

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Summary	of	Benefits	and	Coverage

	hare amounts describe the Enr	ollee's out of pocket costs.	Coinsurant 81.89	e Plan	Gold Copay F 78.4% 78	
	e - AV Calculator			0		. 1%
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible		\$0		\$0	
	ductible, NOT integrated: Me ctible, NOT integrated: Medic		\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
	-of-pocket maximum	ar / i narmacy / Dentar	\$6,000 <u>\$</u> 7		\$6,000 <u>\$</u> 7	
	pocket maximum -only coverage deductible		\$12,000 <u>\$1</u> N/A	<u>4,400</u>	\$12,000 <u>\$1</u> N/A	4,400
	n: Individual deductible		N/A		N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an in	jury, illness, or condition	\$25 <u>\$30</u>		\$25 <u>\$30</u>	
Health care provider's office or clinic visit	Other practitioner office visit		\$ 25 \$30		\$ 25 \$30	
visit	Specialist visit		\$55		\$55	
	Preventive care/ screening/ im	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$55		\$35 \$55	
	Imaging (CT/PET scans, MRIs		20%		\$275	
	Tier 1		\$15		\$15	
Orugs to treat	Tier 2		\$55		\$55	
illness or condition	Tier 3		\$75		\$75	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
Destination i	Surgery facility fee (e.g., ASC)		20%		\$300	
Outpatient services	Physician/surgeon fees		20%		\$40	
	Outpatient visit		20%		20%	
	Emergency room facility fee (w	raived if admitted)	\$325		\$325	
	Emergency room physician fee	(waived if admitted)	No charge		No charge	
Need mmediate	Emergency mMedical transporemergency)	tation (including emergency and non-	\$250		\$250	
attention	Urgent care		\$ 25 \$30		\$ 25 \$30	
Hospital stay	Facility fee (e.g. hospital room		20%		\$600 per day up to 5 days	
,	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health outpa	atient office visits	\$ 25 \$30		\$ 25 \$30	
	Mental/Behavioral health other	outpatient items and services	\$25 \$30		\$25 \$30	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inpat	ient physician fee	20%		to 5 days No charge	
behavioral health, or	ivienta/ benavioral nealth inpat	ent priyacian ree	2076		140 Charge	
substance abuse needs	Substance Use disorder outpa	tient office visits	\$25 <u>\$30</u>		\$25 <u>\$30</u>	
	Substance Use disorder other	outpatient items and services	\$25 <u>\$30</u>		\$ 25 \$30	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatie	ent physician fee	20%		No charge	
	Prenatal care and preconcepti	on visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days No charge	
	Home health care (cost share	per visit)	20%		\$30	
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		\$25 <u>\$30</u> \$25\$30		\$25\$30 \$25\$30	
recovering or other special					\$300 per day up	
nealth needs	Skilled nursing care		20%		to 5 days	
	Durable medical equipment Hospice service		20% No charge		20% No charge	
DI-II-I	Eye exam		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	
21.11.1	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		<u>, , , , , , , , , , , , , , , , , , , </u>		, ,	
and Preventive	Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dontal	Space Maintainers - Fixed				Soc 20402046	
Child Dental Basic	Restorative Procedures		20%		See 20182019 Dental Copay	
Services	Periodontal Maintenance Serv	ices			Schedule	
	Crowns and Casts					
Child Dental	Endodontics	ananaa)	F00/		See 20182019	
Major Services	Periodontics (other than maint Prosthodontics Oral Surgery	enance)	50%		Dental Copay Schedule	
Child	Oral Surgery Medically necessary orthodon	ice	50%		\$1,000	
Orthodontics	ouloung Hecessary Orthodom		JU /0		ψ1,000	

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ounmary of	Benefits and Coverage	Individua	
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver Plan	1
Actuarial Value	e - AV Calculator	71.9% 71.89	<u>%</u>
	cludes a deductible?	Yes, Medical/Pha	armacy
	dividual deductible mily deductible	N/A N/A	
Individual de	ductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500/ \$130 <u>\$20</u>	
	tible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ \$260 <u>\$40</u> \$7,000 <u>\$7,55</u>	
Family Out-of-	pocket maximum	\$14,000 <u>\$15,1</u>	
	only coverage deductible n: Individual deductible	N/A N/A	
noa raililly pia	n. mulviuuai ueuuciibie	IVA	
Common			Deductibl
Medical Event	Service Type	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$40</u>	
Health care provider's office or clinic	Other practitioner office visit	\$35 <u>\$40</u>	
visit	Specialist visit	\$75 <u>\$80</u>	
	Preventive care/ screening/ immunization	No charge	
Footo	Laboratory Tests	\$35	
Гests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$75 \$300	
	Tier 1	\$15	Pharmac
		·	deductibl
Drugs to treat illness or condition	Tier 2	\$55	deductibl
	Tier 3	\$80 20% up to \$250 per	deductibl
	Tier 4	script after pharmacy deductible	Pharmac deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate attention	Emergency mMedical transportation (including emergency and non- emergency)	\$250	Х
	Urgent care	\$35 <u>\$40</u>	
	Facility fee (e.g. hospital room)	20%	Х
Hospital stay	Physician/surgeon fee	20%	×
	Mental/Behavioral health outpatient office visits	\$35 <u>\$40</u>	
	Mental/Behavioral health other outpatient items and services	\$35 <u>\$40</u>	
Mental health.	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
behavioral	Mental/Behavioral health inpatient physician fee	20%	×
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$35 <u>\$40</u>	
	Substance Use disorder other outpatient items and services	\$35 <u>\$40</u>	
	Substance Lies innations facility for (a.g. bosnits!)	20%	Х
	Substance Use inpatient facility fee (e.g. hospital room)		
	Substance use disorder inpatient physician fee	20%	X
Pregnancy	Prenatal care and preconception visits Delivery and all inpatient Hospital	No charge 20%	Х
	Services Professional	20%	X
John	Home health care (cost share per visit) Outpatient Rehabilitation services	\$45 \$35 <u>\$40</u>	
Help recovering or	Outpatient Habilitation services	\$35 <u>\$40</u>	
other special	Skilled nursing care	20%	Х
nealth needs	Durable medical equipment	20%	
	Hospice service Eye exam	No charge No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Obited Day of	Oral Exam		
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		
	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Preventive Child Dental Basic	Space Maintainers - Fixed Restorative Procedures	20%	
and Preventive Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%	
Preventive Child Dental Basic Services	Restorative Procedures	20%	
Preventive Child Dental Basic Services Child Dental	Restorative Procedures Periodontal Maintenance Services Crowns and Casts	20%	
Preventive Child Dental Basic Services Child Dental Major	Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics		
Preventive Child Dental Basic	Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)		

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Date: June	15, 2017 January 11, 2018				
Summary of	Benefits and Coverage	CCSB		CCSB	
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance	Plan	Silver Copay Pla	n
Actuarial Value	e - AV Calculator	71.9%		71.4% <u>71.6</u> °	
Plan design in	cludes a deductible?	Yes, Medical/Ph	armacy	Yes, Medical/Pha	armacy
	dividual deductible	N/A N/A		N/A N/A	
	ımily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$125 <u>\$2</u>	00/\$0	\$2,000 / \$125 <u>\$2</u>	<u>00</u> / \$0
	ctible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$250 <u>\$4</u>		\$4,000 / \$250 <u>\$4</u>	
	-of-pocket maximum pocket maximum	\$7,000 <u>\$7,5</u> \$14,000 <u>\$15,</u>		\$7,000 <u>\$7,55</u> \$14,000 <u>\$15,</u>	
	-only coverage deductible n: Individual deductible	N/A N/A		N/A N/A	
TIOA failing pla	n. marvidual deductible	19/74		IVA	
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	\$45		\$45	
Health care provider's office or clinic	Other practitioner office visit	\$45		\$45	
visit	Specialist visit	\$75 <u>\$80</u>		\$75 <u>\$80</u>	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 \$70\$75		\$40 \$70 \$75	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	\$15	Pharmacy	\$15	Pharmacy
		·	deductible	·	deductible
Drugs to treat illness or condition	Tier 2	\$55	deductible	\$55 	deductible
Condition	Tier 3	\$85 20% up to \$250 per	Pharmacy deductible	\$85 20% up to \$250 per	Pharmacy deductible
	Tier 4 Surgery facility fee (e.g., ASC)	script after pharmacy deductible 20%	Pharmacy deductible	script after pharmacy deductible 20%	Pharmacy deductible
Outpatient services	Surgery lacility lee (e.g., ASC) Physician/surgeon fees Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Emergency mMedical transportation (including emergency and non-	-		-	
immediate	emergency)	\$250	Х	\$250	Х
attention	Urgent care	\$45		\$45	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	Х
, , , , , , , , , , , , , , , , , , , ,	Physician/surgeon fee	20%	Х	20%	X
	Mental/Behavioral health outpatient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	20%		20%	×
health, or substance abuse needs			X	20 /0	77
	Substance Use disorder outpatient office visits	\$45	X	\$45	^
	Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services	\$45 \$45	X		*
	<u> </u>		X	\$45	X
	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room)	\$45 20%		\$45 \$45 20%	
	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee	\$45 20% 20%	X	\$45 \$45 20% 20%	X
Pregnancy	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits	\$45 20% 20% No charge	X X	\$45 \$45 20% 20% No charge	X X
Pregnancy	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee	\$45 20% 20%	X	\$45 \$45 20% 20%	X
Pregnancy	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit)	\$45 20% 20% No charge 20% 20% 20% 20%	X X	\$45 \$45 20% 20% No charge 20% 20% \$45	X X
Help	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services	\$45 20% 20% No charge 20% 20%	X X	\$45 \$45 20% 20% No charge 20% 20%	X X
	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit)	\$45 20% 20% No charge 20% 20% \$45	X X	\$45 \$45 20% 20% No charge 20% \$45 \$45	X X
Help recovering or	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services	\$45 20% 20% No charge 20% 20% \$45 \$45	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45	x x x
Help recovering or other special	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	\$45 20% 20% No charge 20% 20% \$45 \$45 20% And the series of the	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$45 \$0% No charge	x x x
Help recovering or other special	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45 20% No charge No charge	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$40 20% No charge No charge	x x x
Help recovering or other special health needs	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	\$45 20% 20% No charge 20% 20% \$45 \$45 20% And the series of the	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$45 \$0% No charge	X X X
Help recovering or other special health needs Child eye care	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45 20% No charge No charge	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$40 20% No charge No charge	x x x
Help recovering or other special health needs Child eye care Child Dental Diagnostic	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45 20% No charge No charge	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$40 20% No charge No charge	X X X
Help recovering or other special health needs Child eye care	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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	\$45 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$40 No charge No charge No charge	X X X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	\$45 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$40 No charge No charge No charge	X X X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Delivery and all inpatient Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures	\$45 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$40 No charge No charge No charge	X X X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Tooth Topical Fluoride Application Space Maintainers - Fixed	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45 20% No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$45 \$0% No charge No charge No charge No charge	X X X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Delivery and all inpatient Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45 20% No charge No charge No charge	X X X	\$45 \$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$45 \$0% No charge No charge No charge No charge See 20182019 Dental Copay Schedule	x x x
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient Hospital Professional Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45 20% No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$45 \$0% No charge No charge No charge No charge	X X X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Delivery and all inpatient Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45 20% No charge No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$45 \$45 \$45 \$4	x x x

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-	Benefits and Coverage		CCSE Silver	
	hare amounts describe the En	ollee's out of pocket costs.	HDHP P	
	cludes a deductible?		Yes, integr	
Integrated In	dividual deductible		\$ 2,000 \$2,500 i \$ 4,000 \$5,000 i	ntegrated
Individual de	ductible, NOT integrated: Me		N/A	niegraleu
	ctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	N/A \$6,550 <u>\$6</u>	<u>650</u>
	pocket maximum -only coverage deductible		\$13,100 <u>\$13</u> \$2,000 <u>\$2</u>	
	n: Individual deductible		\$2,700	
Common				
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an ir	njury, 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/ in Laboratory Tests	nmunization	No charge 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	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	X
Outpatient services	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	X
services	Outpatient visit		20%	X
	Emergency room facility fee (v	vaived if admitted)	20%	Х
Need	Emergency room physician fer Emergency mMedical transpo	e (waived if admitted) rtation (including emergency and non-	0%	X
mmediate attention	emergency) Urgent care		20%	X
	orgeni care		20%	^
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
	Physician/surgeon fee Mental/Behavioral health outp	atient office visits	20%	X
	Mental/Behavioral health othe	r outpatient items and services	20%	х
	Mental/Rehavioral health inna	tient facility fee (e.g.hospital room)	20%	X
Wental health,				X
pehavioral nealth, or substance abuse needs	Mental/Behavioral health inpa		20%	X
	Cultural line disconder ethor		9994	
	Substance Use disorder other	·	20%	X
	Substance Use inpatient facility		20%	Х
	Substance use disorder inpati		20%	Х
Prognancy	Prenatal care and preconcept		No charge	X
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	X
	Home health care (cost share	per visit)	20%	X
Help recovering or	Outpatient Rehabilitation service Outpatient Habilitation service		20% 20%	X
other special	Skilled nursing care		20%	Х
nealth needs	Durable medical equipment Hospice service		20% 0%	X
Child	Eye exam		No charge	^
Child eye care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures		20%	
Services	Periodontal Maintenance Serv	ices		
Child Dental	Crowns and Casts Endodontics			
Major	Periodontics (other than maint	enance)	50%	
Services	Prosthodontics			
	Oral Surgery			

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Summary	v of	Benefits	and	Coverage

	hare amounts describe the En	rollee's out of pocket costs.	Silver F 100%-150	% FPL	Silver Plan 150%-200% F	PL
	e - AV Calculator cludes a deductible?		93.9% <u>94</u> Yes, Medical/		88.0%87.9% Yes, Medical/Pha	
Integrated Inc	dividual deductible		N/A		N/A	macy
	mily deductible ductible, NOT integrated: Me	edical / Pharmacy / Dental	N/A \$75 / \$0		N/A \$650 / \$50 / \$	60
Family deduc	tible, NOT integrated: Medic		\$150 / \$0	0/\$0	\$1,300 / \$100 /	\$0
Family Out-of-	-of-pocket maximum pocket maximum		\$1,00 \$2,00		\$2,450 <u>\$2,60</u> \$4,900 <u>\$5,2</u> 0	
HSA plan: Self-	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
nom raininy piai	n. marviduai 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	\$5		\$ 10 \$15	
Health care provider's office or clinic	Other practitioner office visit		\$5		\$ 10 \$15	
visit	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	n .	\$8 \$8		\$15 \$25\$30	
	Imaging (CT/PET scans, MRI		\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat	Tier 2		\$10		\$20	Pharmac deductib
condition	Tier 3		\$15		\$35	Pharmac deductible
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmac deductib
Outpatient	Surgery facility fee (e.g., ASC		10%		15%	
services	Physician/surgeon fees Outpatient visit		10% 10%		15% 15%	
	Emergency room facility fee (vaived if admitted)	\$50		\$100	
		· · · · · · · · · · · · · · · · · · ·			·	
Need	Emergency room physician fe	<u>'</u>	No charge		No charge	
	emergency)	rtation (including emergency and non-	\$30	Х	\$75	Х
	Urgent care		\$5		\$ 10 \$15	
Hospital stay	Facility fee (e.g. hospital room)	10%	Х	15%	Х
, , , , , , ,	Physician/surgeon fee		10%	X	15%	×
	Mental/Behavioral health outp	atient office visits	\$5		\$10 <u>\$15</u>	
	Mental/Behavioral health othe	r outpatient items and services	\$5		\$ 10 \$15	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health,	Mental/Behavioral health inpa	tient physician fee	10%	×	15%	×
behavioral health, or substance	Werta/Beriavioral Health Impa	uent physician lee	10%	*	1576	*
abuse needs	Substance Use disorder outp	atient office visits	\$5		<u>\$10</u> <u>\$15</u>	
	Substance Use disorder othe	outpatient items and services	\$5		\$ 10 \$15	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	10%	х	15%	Х
	Substance use disorder inpat	ent physician fee	10%	×	15%	×
	Prenatal care and preconcept		No charge		No charge	
	Delivery and all inpatient	Hospital	10%	Х	15%	Х
	services	Professional	10%	X	15%	×
	Home health care (cost share	per visit)	\$3		\$15	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$5 \$5		\$10 <u>\$15</u> \$10 <u>\$15</u>	
recovering or	Skilled nursing care		10%	Х	15%	Х
health needs	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or or o	contact lenses in lieu of glasses)	No charge No charge		No charge No charge	
	Oral Exam	<u> </u>			3-	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge		No charge	
	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental						
Basic	Restorative Procedures		20%		20%	
Services	Periodontal Maintenance Service Crowns and Casts	rices				
	Endodontics					
Major	Periodontics (other than main	tenance)	50%		50%	
Services	Prosthodontics Oral Surgery					
Child						
Orthodontics	Medically necessary orthodor	tics	50%		50%	

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Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan 200%-250% FP	L
Actuarial Value	- AV Calculator		73.9%	
	cludes a deductible?		Yes, Medical/Pharr	macy
	dividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: Me tible, NOT integrated: Medic		\$2,200 / \$130 \$175	
ndividual Out-	-of-pocket maximum	ai / Filamiacy / Dentai	\$4,400 / <u>\$260</u> \$350 \$5,850 <u>\$6,300</u>	
	oocket maximum only coverage deductible		\$11,700 <u>\$12,60</u> N/A	0
	n: Individual deductible		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an i	njury, illness, or condition	\$ 30 \$35	
Health care provider's office or clinic	Other practitioner office visit		\$ 30 \$35	
visit	Specialist visit		\$75	
	Preventive care/ screening/ in	nmunization	No charge	
F4-	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI:		\$75 \$300	
		-/		Pharmad
	Tier 1	\$15	deductib	
Drugs to treat illness or condition	Tier 2		\$50	Pharmad
	Tier 3		\$75	Pharmac deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees Outpatient visit		20% 20%	
	Emergency room facility fee (waived if admitted)	\$350	
		·		
Need	Emergency room physician fe		No charge	
mmediate	emergency)	rtation (including emergency and non-	\$250	Х
attention	Urgent care		\$ 30 \$35	
Hospital stay	Facility fee (e.g. hospital room	1)	20%	Х
nospital stay	Physician/surgeon fee		20%	-X-
	Mental/Behavioral health outp	atient office visits	\$ 30 \$35	
	Mental/Behavioral health othe	r outpatient items and services	\$ 30 \$35	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa		20%	×
health, or substance	Substance Use disorder outpa	\$ 30 \$35		
abuse needs	·			
	Substance Use disorder other	outpatient items and services	\$ 30 <u>\$35</u>	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat	ent physician fee	20%	×
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care (cost share Outpatient Rehabilitation serv		\$40 \$30\$35	
Help recovering or	Outpatient Habilitation service		\$ 30 \$35	
other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
	Oral Exam	. 57	 g-	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures		20%	
Services	Periodontal Maintenance Serv	vices		
	Crowns and Casts Endodontics			
Child Dental Major	Periodontics (other than main	tenance)	50%	
Services	Prosthodontics	·		
	Oral Surgery			

Medically necessary orthodontics

50%

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Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	Bronz HDHP P	
Actuarial Value	e - AV Calculator	60.8% <u>60.9</u> %	<u>6</u>	61.4% <u>61</u>	.6%
	cludes a deductible?	Yes, Medical/Pha	rmacy	Yes, integ	
	dividual deductible imily deductible	N/A N/A		\$4,800 <u>\$6,000</u> i \$9,600 <u>\$12,000</u>	
	ductible, NOT integrated: Medical / Pharmacy / Dental ctible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 \$13,600 / \$1,00		N/A N/A	
	-of-pocket maximum	\$12,600 / \$1,00 \$7,000 <u>\$7,55</u>		\$6,550 <u>\$6</u>	.650
	pocket maximum -only coverage deductible	\$14,000 \$ <u>15,1</u> N/A	00	\$13,100 <u>\$1</u> \$4.80	
	n: Individual deductible	N/A		\$4,800	
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	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 100%	X	40% 40%	X
10010	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
Out	Surgery facility fee (e.g., ASC)	100%	X	40%	Х
Outpatient services	Physician/surgeon fees	100%	X	40%	Х
	Outpatient visit	100%	X	40%	X
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need immediate	Emergency mMedical transportation (including emergency and non- emergency)	100%	Х	40%	Х
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	Х
Hospital stay	Facility fee (e.g. hospital room)	100%	X	40%	Х
nospitai stay	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,	Mental/Behavioral health inpatient physician fee	100%	X	40%	X
behavioral health, or	wentarbenavioral nearit inparient physician ree	10076	After 1st three	40 /6	^
substance abuse needs	Substance Use disorder outpatient office visits	\$75	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 services	100%	Х	40%	Х
	Professional	100%	X	40%	X
	Home health care (cost share per visit) Outpatient Rehabilitation services	100% \$75	X	40% 40%	X
Help recovering or	Outpatient Habilitation services	\$75		40%	X
other special	Skilled nursing care	100%	Х	40%	Х
health needs	Durable medical equipment	100%	X	40%	Х
	Hospice service Eye exam	No charge No charge		0% No charge	X
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	J-			
Child Dental Diagnostic	Preventive - Cleaning				
and	Preventive - X-ray Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental					
Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Prosthodontics Oral Surgery				

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Summary of Benefits and Coverage	
Member Cost Share amounts describe the Enrollee's out of pocket costs.	

Member Cost SI	Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs.	Catastro	phic Plan
Actuarial Value	- AV Calculator		
	cludes a deductible?		egrated
	dividual deductible		00 integrated
	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental		300 integrated /A
Family deduc	ctible, NOT integrated: Medical / Pharmacy / Dental		/A
	-of-pocket maximum pocket maximum		\$7,900 \$15,800
HSA plan: Self-	only coverage deductible	N	/A
HSA family pla	n: Individual deductible	N	/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits
Health care provider's office or clinic	Other practitioner office visit	0%	After 1st three non-preventive visits
visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0% 0%	X
	illiaging (CT/FET Scalls, MINIS)	0%	^
	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) Physician/surgeon fees	0%	X
services	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
	Emergancy room physician for (university of if admitted)	No oborgo	
Need immediate	Emergency room physician fee (waived if admitted) Emergency mMedical transportation (including emergency and non-emergency)	No charge	Х
attention	Urgent care	0%	After 1st three non-preventive
	Facility fee (e.g. hospital room)	0%	visits
Hospital stay	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 health,	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	Х
behavioral	Mental/Behavioral health inpatient 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 facility fee (e.g. hospital room)	0%	Х
	Substance use disorder inpatient physician fee	0%	Х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital	0%	Х
	services Professional	0%	Х
	Home health care (cost share per visit) Outpatient Rehabilitation services	0%	X
Help	Outpatient Renabilitation services Outpatient Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
yo sui o	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
Child Dental	Oral Exam Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth Topical Elucido Application	140 charge	
. revenuve	Topical Fluoride Application Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	Х
	Periodontal Maintenance Services Crowns and Casts		X
Services	Endodontics		X
Services Child Dental Major	Periodontics (other than maintenance)	0%	X
Child Dental	Periodontics (other than maintenance) Prosthodontics Oral Surgery	0%	X X X

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.			Platinu		Platinum	
	e - AV Calculator	onder out of poorter occio.	Coinsurance 91.2%91		Copay Plan 88.1%88.9%	
Plan design in	cludes a deductible?		No		No	
	dividual deductible mily deductible		\$0 \$0		\$0 \$0	
Individual de	ductible, NOT integrated: Me		\$0 / \$0 /		\$0 / \$0 / \$0	
	ctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$0 / \$0 / \$3,350		\$0 / \$0 / \$3,350	
	pocket maximum -only coverage deductible		\$6,700 N/A)	\$6,700 N/A)
	n: Individual deductible		N/A		N/A	
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event		rvice Type	Share	Applies	Share	Applies
Health care	Primary care visit to treat an in	njury, illness, or condition	\$15		\$15	
provider's office or clinic visit	Other practitioner office visit		\$15		\$15	
	Specialist visit		\$30		\$30	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$15		No charge \$15	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$30 10%		\$30	
		5)			\$75	
	Tier 1		\$5 		\$5 	
Drugs to treat	Tier 2		\$15		\$15	
condition	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		10% 10%		\$100 \$25	
services	Outpatient visit		10%		10%	
	Emergency room facility fee (v	vaived if admitted)	\$150		\$150	
	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
Need immediate	Emergency mMedical transpo emergency)	rtation (including emergency and non-	\$150		\$150	
attention	Urgent care				\$15	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee		10%		No charge	
	Mental/Behavioral health outp	\$15		\$15		
	Mental/Behavioral health othe	r outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	10%		No charge	
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$15		\$15	
	Substance Use disorder other	outpatient items and services	\$15		\$15	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpati	ent physician fee	10%		No charge	
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services Home health care (cost share	Professional	10% 10%		No charge \$20	
Help	Outpatient Rehabilitation serv	ices	\$15		\$15	
recovering or	Outpatient Habilitation service	S	\$15		\$15 \$150 per day up	
other special health needs	Skilled nursing care		10%		to 5 days	
	Durable medical equipment Hospice service		10% No charge		10% No charge	
Child eye care	Eye exam		No charge		No charge	
7.00.0	1 pair of glasses per year (or of Oral Exam	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Service Crowns and Casts	rices			Not Covered	
Child Dental	Endodontics				Not Covered	
Major Services	Periodontics (other than main	enance)	Not Covered		Not Covered	
30,77003	Prosthodontics Oral Surgery				Not Covered Not Covered	
Child	Medically necessary orthodon	tics	Not Covered		Not Covered	
Orthodontics	Miculcally Hecessary Offiliodon	100	Not Covered		Not Covered	

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Summary	of	Ranafite	and	Coverage

-	Benefits and Coverage hare amounts describe the Enr	ollee's out of pocket costs.	Gold Coinsurand		Gold Copay P	
Actuarial Value	e - AV Calculator		81.89	6	78.4% <u>78</u>	
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible		\$0		\$0	
	ductible, NOT integrated: Me ctible, NOT integrated: Medic		\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 \$0 / \$0 / \$0	
	-of-pocket maximum	ar / Finarmacy / Demai	\$6,000 <u>\$</u> 7		\$6,000 <u>\$</u> 7	
	pocket maximum -only coverage deductible		\$12,000 <u>\$1</u> N/A		\$12,000 <u>\$1</u> N/A	4,400
	n: Individual deductible		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	jury, illness, or condition	\$25 <u>\$30</u>		\$25 <u>\$30</u>	
Health care provider's office or clinic	Other practitioner office visit		\$25 <u>\$30</u>		\$25 <u>\$30</u>	
visit	Specialist visit		\$55		\$55	
	Preventive care/ screening/ im	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$55		\$35 \$55	
	Imaging (CT/PET scans, MRIs		20%		\$275	
	Tier 1		\$15		\$15	
Drugs to treat illness or	Tier 2		\$55		\$55	
condition	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) Physician/surgeon fees		20%		\$300 \$40	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (v	raived if admitted)	\$325		\$325	
	Emergency room physician fee	(waived if admitted)	No charge		No charge	
Need immediate		tation (including emergency and non-			\$250	
attention	Urgent care		\$ 25 \$30		\$ 25 \$30	
Hospital stay	Facility fee (e.g. hospital room	20%		\$600 per day up to 5 days		
	Physician/surgeon fee		20%		No charge	
	Mental/Behavioral health outpa	\$25 <u>\$30</u>		\$25 <u>\$30</u>		
	Mental/Behavioral health other	\$25 <u>\$30</u>		\$25 <u>\$30</u>		
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,					to 5 days	
behavioral health, or	Mental/Behavioral health inpat	ent physician fee	20%		No charge	
substance abuse needs	Substance Use disorder outpa	tient office visits	\$25 <u>\$30</u>		\$25 <u>\$30</u>	
	Substance Use disorder other	\$25 <u>\$30</u>		\$25 <u>\$30</u>		
	Substance Use inpatient facilit	v fee (e.g. hospital room)	20%		\$600 per day up	
	Substance use disorder inpatie		20%		to 5 days No charge	
	Prenatal care and preconcepti		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
regnancy	services	<u> </u>			to 5 days	
	Home health care (cost share	Professional per visit)	20%		No charge \$30	
Help	Outpatient Rehabilitation servi	ces	\$25 <u>\$30</u>		\$25 <u>\$30</u>	
recovering or	Outpatient Habilitation service	S	\$25 <u>\$30</u>		\$25\$30 \$300 per day up	
other special health needs	Skilled nursing care		20%		to 5 days	
	Durable medical equipment Hospice service		20% No charge		20% No charge	
	Eye exam		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		·		·	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Serv	ices			N. C	
Child Daniel	Crowns and Casts Endodontics				Not Covered Not Covered	
Child Dental Major	Periodontics (other than maint	enance)	Not Covered		Not Covered	
Services	Prosthodontics	·			Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodon	ics	Not Covered		Not Covered	
Orthodontics						

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Summary of Benefits and Coverage	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan
Actuarial Value - AV Calculator	71.9% 71.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500/ \$130 \$200 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ \$260 \$400 / \$0
Individual Out-of-pocket maximum	\$7,000 \$7,550
Family Out-of-pocket maximum	\$14,000 <u>\$15,100</u>
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

	-of-pocket maximum pocket maximum	\$7,000\$7,55 \$14,000\$15,1	
	only coverage deductible	N/A	
HSA family pla	n: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Delvice Type		, de la co
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$40</u>	
U. de la comp			
Health care provider's	Other practitioner office visit	\$35 \$40	
office or clinic	Carlot production critica viola	φου <u>φνυ</u>	
visit			
	Specialist visit	\$75 <u>\$80</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Tests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharmacy
			deductible
5	Tier 2	\$55	Pharmacy
Drugs to treat illness or		,,,,	deductible
condition	Tier 3	\$80 \$90	Pharmacy
	1161 3	\$50 \$50	deductible
		20% up to \$250 per	Pharmacy
	Tier 4	script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Emergency mMedical transportation (including emergency and non-	g-	
immediate	emergency)	\$250	Х
attention			
	Urgent care	\$35 \$40	
		· -	
	F94. f (b4-1)	000/	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
	Physician/surgeon fee	20%	×
	Mental/Behavioral health outpatient office visits	\$25\$40	
	Menta/Benavioral nealth outpatient office visits	\$35 <u>\$40</u>	
	Mental/Behavioral health other outpatient items and services	\$35 <u>\$40</u>	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health,	Mental/Behavioral health inpatient physician fee	20%	×
behavioral health, or	mental/Benavioral neath inpatient physician rec	2070	*
substance	Substance Use disorder outpatient office visits	\$35 \$40	
	Substance Ose disorder outpatient office visits	\$00	
abuse needs			
abuse needs			
abuse needs	Substance Use disorder other outpatient items and services	\$35 \$40	
abuse needs	Substance Use disorder other outpatient items and services	\$35 <u>\$40</u>	
abuse needs	·	· -	Y
abuse needs	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room)	\$35 <u>\$40</u> 20%	Х
abuse needs	·	· -	X X
abuse needs	Substance Use inpatient facility fee (e.g. hospital room)	20%	
Pregnancy	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee	20%	
	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital	20% 20% No charge	X
	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit)	20% 20% No charge 20%	×
	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services	20% 20% No charge 20% 20% \$45 \$35\$40	×
Pregnancy Help recovering or	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services	20% 20% No charge 20% 20% \$45 \$35\$40 \$35\$40	×
Pregnancy Help recovering or other special	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services	20% 20% No charge 20% 20% \$45 \$35\$40	×
Pregnancy Help recovering or other special	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment	20% 20% No charge 20% \$45 \$35\$40 \$20% 20% 20%	X X X
Pregnancy Help recovering or	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge	X X X
Pregnancy Help recovering or other special	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge No charge	X X X
Pregnancy Help recovering or other special health needs	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient Hospital Professional Home health care (cost share per visit) Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge	X X X
Pregnancy Help recovering or other special health needs	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - V-ray Sealants per Tooth	20% 20% No charge 20% \$45 \$35\$40 \$20% 20% No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray	20% 20% No charge 20% \$45 \$35\$40 \$20% 20% No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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	20% 20% No charge 20% \$45 \$36\$40 \$36\$40 20% No charge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures	20% 20% No charge 20% \$45 \$35\$40 \$20% 20% No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services Crowns and Casts	20% 20% No charge 20% \$45 \$36\$40 \$36\$40 20% No charge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services	20% 20% No charge 20% \$45 \$36\$40 \$36\$40 20% No charge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services Crowns and Casts	20% 20% No charge 20% \$45 \$36\$40 \$36\$40 20% No charge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child bental Diagnostic and Preventive Child Dental Basic Services Child Dental	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge No charge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Delivery and all inpatient Professional Home health care (cost share per visit) Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge No charge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care (cost share per visit) Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 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 Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	20% 20% No charge 20% \$45 \$35\$40 \$35\$40 20% No charge No charge No charge No charge No charge	X X X

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Summary of	Benefits and Coverage	CCSB		CCSB		
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan		Silver Copay Plan		
Actuarial Value	e - AV Calculator	71.9%		71.4% 71.6		
Plan design in	cludes a deductible?	Yes, Medical/Ph	armacy	Yes, Medical/Pharmacy		
	dividual deductible	N/A N/A		N/A N/A		
	amily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$125 <u>\$2</u>	<u>900</u> / \$0	\$2,000 / \$125 <u>\$2</u>	00 / \$0	
	ctible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$250 <u>\$4</u>		\$4,000 / \$250 <u>\$4</u>		
	-of-pocket maximum pocket maximum	\$ 7,000 <u>\$7,5</u> \$14,000 <u>\$</u> 15,		\$7,000 <u>\$7,5</u> \$14,000 <u>\$15.</u>		
	only coverage deductible	N/A		N/A		
nsa ramily pia	in: individual deductible	N/A		N/A		
Common			Deductible		Deductible	
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies	
	Primary care visit to treat an injury, illness, or condition	\$45		\$45		
	, , , , , , , , , , , , , , , , , , ,					
Health care provider's	Other practitioner office visit	\$45		\$45		
office or clinic		ΨΨΟ		ψ43		
visit	Specialist visit	\$75 \$80		\$75\$90		
	Specialist visit	<u>₩79</u> ₩00		\$75 <u>\$80</u>		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 \$ 70 \$75		\$40 \$70\$75		
	Imaging (CT/PET scans, MRIs)	20%		\$300		
	Tier 1	\$15	Pharmacy deductible	\$15	Pharmacy deductible	
			deductible		deductible	
Drugs to treat	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible	
illness or						
condition	Tier 3	\$85	Pharmacy deductible	\$85	Pharmacy deductible	
		20% up to \$250 per		20% up to \$250 per		
	Tier 4	script after pharmacy deductible	Pharmacy deductible	script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC)	20%		20%		
services	Physician/surgeon fees 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	Emergency mMedical transportation (including emergency and non- emergency)	\$250	Х	\$250	Х	
attention						
	Urgent care	\$45		\$45		
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	Х	
1103pitai stay	Physician/surgeon fee	20%	Х	20%	×	
	Mental/Behavioral health outpatient office visits	\$45		\$45		
	Mental/Behavioral health other outpatient items and services	\$45		\$45		
Mental health,	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х	20%	Х	
behavioral	Mental/Behavioral health inpatient physician fee	20%	Х	20%	X	
health, or substance						
abuse needs	Substance Use disorder outpatient office visits	\$45		\$45		
	Substance Use disorder other outpatient items and services	\$45		\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х	20%	Х	
	Substance use disorder inpatient physician fee	20%	Х	20%	×	
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital	20%	Х	20%	Х	
	services Professional	20%	Х	20%	×	
	Home health care (cost share per visit) Outpatient Rehabilitation services	20% \$45		\$45 \$45		
Help recovering or	Outpatient Rehabilitation services Outpatient Habilitation services	\$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		No charge		No charge		
	Oral Exam	· ·		_		
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application Space Maintainers - Fixed	1				
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
	Crowns and Casts			Not Covered		
Child Dental	Endodontics Periodontics (other than maintanance)	Not Covered		Not Covered		
Major Services	Periodontics (other than maintenance) Prosthodontics	Not Covered		Not Covered Not Covered		
	Oral Surgery			Not Covered Not Covered		
Child	Medically necessary orthodontics	Not Covered		Not Covered		
Orthodontics						

2018DRAFT 2019 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 15, 2017 January 11, 2018

Summary of	+15, 2017 January 11, Benefits and Coverage		CCSB		
Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver HDHP PI		
Actuarial Value - AV Calculator			71.7% <u>70.5%</u>		
Plan design in	cludes a deductible?		Yes, integr	ated	
Integrated Inc	dividual deductible		\$ 2,000 \$2,500 ir	ntegrated	
	imily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$4,000 \$5,000 ir N/A	ntegrated	
	ctible, NOT integrated: Medic	al / Pharmacy / Dental	N/A	050	
	-of-pocket maximum pocket maximum		\$6,550 <u>\$6,</u> \$13,100 <u>\$</u> 13		
	only coverage deductible n: Individual deductible		\$2,000 <u>\$2,</u> \$2,700		
noa ranniy pia	in: marviduar deductible		\$2,700		
Common Medical Event		nder Tomo	Member Cost Share	Deductible Applies	
Medical Event		rvice Type			
Health care	Primary care visit to treat an ir	njury, illness, or condition	20%	Х	
provider's office or clinic visit	Other practitioner office visit		20%	Х	
	Specialist visit		20%	Х	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge 20%	X	
Tests	X-rays and Diagnostic Imaging		20%	Х	
	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) Physician/surgeon fees		20% 20%	X	
services	Outpatient visit		20%	X	
	Emergency room facility fee (v	vaived if admitted)	20%	Х	
	Emorgonov room physician fo	(waived if admitted)	0%	Х	
Need	Emergency room physician fe		0%	^	
immediate	emergency) emergency)	rtation (including emergency and non-	20%	Х	
attention	Urgent care		20%	х	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	
	Physician/surgeon fee		20%	X	
	Mental/Behavioral health outpatient office visits		20%	Х	
	Mental/Behavioral health other outpatient items and services		20%	Х	
	Mental/Behavioral health inna	tient facility fee (e.g.hospital room)	20%	Х	
Mental health,	· ·				
behavioral health, or	Mental/Behavioral health inpa	tient physician fee	20%	Х	
substance abuse needs	Substance Use disorder outpatient office visits		20%	Х	
	Substance Use disorder other outpatient items and services		20%	Х	
	Substance Use inpatient facilit	ry fee (e.g. hospital room)	20%	Х	
	Substance use disorder inpati	ent physician fee	20%	Х	
	Prenatal care and preconcept		No charge	^	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	
ognanoj	services	Professional	20%	X	
	Home health care (cost share	per visit)	20%	X	
Help	Outpatient Rehabilitation service		20%	X	
recovering or	Outpatient Habilitation service	0	20%		
other special health needs	Skilled nursing care		20%	X	
	Durable medical equipment Hospice service		20% 0%	X	
	Eye exam		No charge	^	
Child eye care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge		
	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		
. 70 Tendve	Space Maintainers - Fixed				
Child Dental	Restorative Procedures		N-d O		
Basic Services		icas	Not Covered		
	Periodontal Maintenance Service Crowns and Casts	ices			
Child Dental	Endodontics				
Major	Periodontics (other than maint	enance)	Not Covered		
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodon	tics	Not Covered		
Orthodontics					

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Member Cost S	mary of Benefits and Coverage er Cost Share amounts describe the Enrollee's out of pocket costs. rial Value - AV Calculator 93.9%94.2%		% FPL	Silver Plan 150%-200% FPL 88.0%87.9%		
Plan design in	cludes a deductible?		Yes, Medical/I	Pharmacy	Yes, Medical/Pha	-
Integrated Fa	dividual deductible mily deductible ductible, NOT integrated: Me ctible, NOT integrated: Medic		N/A N/A \$75 / \$0 / \$0 \$150 / \$0 / \$0		N/A N/A \$650 / \$50 / \$ \$1,300 / \$100 /	
Individual Out-	-of-pocket maximum pocket maximum	ar / Frial mady / Bernar	\$1,00 \$2,00	0	\$2,450 <u>\$2,60</u> \$4,900 <u>\$5,20</u>	0
HSA plan: Self-	-only coverage deductible in: Individual deductible		N/A		N/A	<u>U</u>
HSA family pla	in: individual deductible		N/A		N/A	
Common Medical Event	Se	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$5		\$10 <u>\$15</u>	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$ 10 \$15	
Viole	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$8		No charge \$15	
Tests	X-rays and Diagnostic Imagin		\$8		\$25 <u>\$30</u>	
	Imaging (CT/PET scans, MRIs	i)	\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat illness or	Tier 2		\$10		\$20	Pharmacy deductible
condition	Tier 3		\$15		\$35 15% up to \$150 per	Pharmacy deductible
	Tier 4		10% up to \$150 per script		script after pharmacy	Pharmacy deductible
	Surgery facility fee (e.g., ASC		10%		deductible 15%	
Outpatient services	Physician/surgeon fees		10%		15%	
	Outpatient visit Emergency room facility fee (v	vaived if admitted)	10% \$50		15% \$100	
	Emergency room physician fe				· ·	
Need	<u> </u>	tation (including emergency and non-	No charge		No charge	
immediate attention	emergency)	tation <u>(including only gone) and non-</u>	\$30	Х	\$75	Х
attention	Urgent care		\$5		\$ 10 \$15	
	Facility fee (e.g. hospital room)	10%	X	15%	Х
Hospital stay	Physician/surgeon fee		10%	X	15%	×
	Mental/Behavioral health outp	\$5		\$ 10 \$15		
	Mental/Behavioral health othe	\$5		\$ 10 \$15		
	Mental/Behavioral health inpa	ient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health, behavioral	Mental/Behavioral health inpa	ient physician fee	10%	Х	15%	×
health, or substance abuse needs	Substance Use disorder outpa	\$5		\$ 10 \$15		
	Substance Use disorder other	\$5		\$ 10 \$15		
	Substance Use inpatient facili	y fee (e.g. hospital room)	10%	Х	15%	Х
	Substance use disorder inpati	ent physician fee	10%	х	15%	×
	Prenatal care and preconcept	on visits	No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	10%	Х	15%	Х
	Home health care (cost share	Professional per visit)	10% \$3	Х	15% \$15	×
Help	Outpatient Rehabilitation serv	ces	\$5		\$10 <u>\$15</u>	
recovering or	Outpatient Habilitation service	S	\$5	V	\$10 <u>\$15</u>	V
other special health needs	Skilled nursing care Durable medical equipment		10%	Х	15% 15%	Х
	Hospice service		No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or or	ontact langue in liqu of alacess	No charge		No charge	
	Oral Exam	ontaot lenses in lieu or giasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Service Crowns and Casts	ices	Not Covered		Not Covered	
Child Dental	Endodontics					
Major Services	Periodontics (other than main	enance)	Not Covered		Not Covered	
Ger vices	Prosthodontics Oral Surgery					
Child Orthodontics	Medically necessary orthodon	tics	Not Covered		Not Covered	

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Summary of Benefits and Coverage

	hare amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FF	PL .
	- AV Calculator	73.9%	
Integrated In	cludes a deductible? dividual deductible	Yes, Medical/Phari N/A	macy
	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$2,200 / \$130 \$175	5 / \$0
Family deduc	ctible, NOT integrated: Medical / Pharmacy / Dental	\$4,400 / \$260 <u>\$350</u>	/ \$0
	-of-pocket maximum pocket maximum	\$5,850 <u>\$6,300</u> \$11,700 <u>\$12,60</u>	
	-only coverage deductible n: Individual deductible	N/A N/A	
nor ranny pia	III III III III III III III III III II	1471	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$30 <u>\$35</u>	
Health care provider's office or clinic	Other practitioner office visit	\$ 30 \$35	
visit	Specialist visit	\$7 5	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharmac deductibl
Drugs to treat	Tier 2	\$50	Pharmac deductibl
illness or condition	Tier 3	\$75	Pharmac deductibl
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductibl
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Emergency mMedical transportation (including emergency and non-	-	Х
immediate attention	emergency)	Ψ230	^
	Urgent care	\$ 30 \$35	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
	Physician/surgeon fee	20%	-X
	Mental/Behavioral health outpatient office visits	\$30 \$35	
	Mental/Behavioral health other outpatient items and services	\$ 30 \$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health,		20%	×
behavioral health, or	Mental/Behavioral health inpatient physician fee	20%	*
substance abuse needs	Substance Use disorder outpatient office visits	\$ 30 \$35	
	Substance Use disorder other outpatient items and services	\$ 30 \$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient physician fee	20%	×
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital services	20%	Х
	Professional Home health care (cost share per visit)	20% \$40	X
Help	Outpatient Rehabilitation services	\$30 <u>\$35</u>	
recovering or	Outpatient Habilitation services	\$30 <u>\$35</u>	
other special health needs	Skilled nursing care	20%	Х
	Durable medical equipment Hospice service	20% No charge	
Child eye care	Eye exam	No charge	
,	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge	
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
and			
and Preventive Child Dental	Space Maintainers - Fixed Restorative Procedures	Not Covered	
and Preventive Child Dental Basic	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services	Not Covered	
and Preventive Child Dental Basic Services	Space Maintainers - Fixed Restorative Procedures	Not Covered	
and Preventive Child Dental Basic	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts	Not Covered Not Covered	
and Preventive Child Dental Basic Services Child Dental	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics		
and Preventive Child Dental Basic Services Child Dental Major	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)		

Medically necessary orthodontics

Not Covered

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Summary	of	Benefits	and	Covera	ae

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Bronze Pla	n	Bronze HDHP Plan		
Actuarial Value	e - AV Calculator	60.8% 60.99	6	61.4% <u>61</u>	.6%	
	cludes a deductible?	Yes, Medical/Pha	ırmacy	Yes, integ		
	dividual deductible imily deductible	N/A N/A		\$4,800 <u>\$6,000</u> i \$9,600\$12,000		
Individual de	ductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500		N/A	Ŭ	
	ctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$12,600 / \$1,00 \$7,000 \$7,55		N/A \$6,550 <u>\$6</u>	,650	
amily Out-of-	pocket maximum	\$14,000 \$ <u>15,1</u>		\$13,100 <u>\$1</u>	3,300	
	-only coverage deductible ın: Individual deductible	N/A N/A		\$4,800 \$4,800		
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	\$75	After 1st three non-preventive visits	40%	х	
lealth care provider's office or clinic	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	х	
risit	Specialist visit	\$105	After 1st three non-preventive visits	40%	х	
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 100%	X	40% 40%	X	
10313	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	
Orugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
llness 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	
	Surgery facility fee (e.g., ASC)	100%	X	40%	X	
Outpatient services	Physician/surgeon fees	100%	X	40%	Х	
	Outpatient visit	100%	X	40%	X	
	Emergency room facility fee (waived if admitted)	100%	Х	40%	Х	
	Emergency room physician fee (waived if admitted)	No charge		0%	Х	
Need mmediate	Emergency mMedical transportation (including emergency and non- emergency)	100%	Х	40%	Х	
attention	Urgent care	\$75	After 1st three non-preventive visits	40%	х	
Hospital stay	Facility fee (e.g. hospital room)	100%	Х	40%	Х	
	Physician/surgeon fee	100%	Х	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, behavioral	Mental/Behavioral health inpatient physician fee	100%	Х	40%	Х	
health, or 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	X	40%	Х	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	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 services Hospital	100%	X	40%	X	
	Professional Home health care (cost share per visit)	100%	X	40%	X	
Help	Outpatient Rehabilitation services	\$75		40%	Х	
recovering or	Outpatient Habilitation services	\$75		40%	Х	
other special health needs	Skilled nursing care	100%	Х	40%	Х	
	Durable medical equipment	100% No charge	X	40% 0%	X	
	Hospice service Eye exam	No charge		No charge	^	
Child eye care		No charge		No charge		
	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			<u>-</u>		
and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Services Crowns and Casts					
	Endodontics					
Child Dental						
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
		Not Covered		Not Covered		
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	\$7,350 <u>\$7,900</u> integrated
Integrated Family deductible	\$14,700 <u>\$15,800</u> integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A

N/A N/A \$7,350<u>\$7,900</u> \$14,700<u>\$15,800</u> N/A ly deductible, NOT integrated: Medical / Pharmacy / Dental ual Out-of-pocket maximum Out-of-pocket maximum After 1st three non-preventive Primary care visit to treat an injury, illness, or condition 0% After 1st three Other practitioner office visit 0% provider's office or clin non-preventive visits Specialist visit 0% Χ Preventive care/ screening/ immunization No charge X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tests Χ Tier 2 0% Х Drugs to treat illness or condition Tier 3 0% Χ Tier 4 0% Χ Surgery facility fee (e.g., ASC) Physician/surgeon fees 0% Χ Outpatient visit Emergency room facility fee (waived if admitted) 0% Х Emergency room physician fee (waived if admitted) No charge Emergency mMedical transportation (including emergency and non-0% After 1st three 0% Facility fee (e.g. hospital room) lospital stay Physician/surgeon fee After 1st three Mental/Behavioral health outpatient office visits 0% Mental/Behavioral health other outpatient items and services 0% Х Mental/Behavioral health inpatient facility fee (e.g.hospital room) 0% Χ Mental/Behavioral health inpatient physician fee 0% Х oehavioral nealth, or Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services 0% Х Substance Use inpatient facility fee (e.g. hospital room) 0% Х Substance use disorder inpatient physician fee Χ Prenatal care and preconception visits No charge Delivery and all inpatient Hospital services 0% Х Professional Home health care (cost share per visit) Outpatient Rehabilitation services 0% 0% X Outpatient Habilitation services Skilled nursing care 0% Х Durable medical equipment 0% Hospice service Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) 0% Х Oral Exam
Preventive - Cleaning
Preventive - X-ray
Sealants per Tooth
Topical Fluoride Application Child Dental Not Covered Space Maintainers - Fixed Child Dental Restorative Procedures Periodontal Maintenance Services
Crowns and Casts
Endodontics Endodontics

Child Dental

Periodontics (other than maintenance)

Not Covered

Medically necessary orthodontics

Prosthodontics Oral Surgery

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

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

- 24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.

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