# Covered California ~~2018~~ 2019 Patient-Centered Benefit Plan Designs[1]

## ~~Final~~ Draft ~~Board-approved~~Plan Designs for Discussion

## ~~June 15, 2017~~[2] [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~~

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


**Summary of Benefits and Coverage**

Member Cost Share amounts describe the Enrollee's out of pocket costs.

| | Platinum Coinsurance Plan | Platinum Copay Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | ~~91.2%~~91.7% | ~~88.1%~~88.9% |
| **Plan design includes a deductible?** | No | No |
| **Integrated Individual deductible** | $0 | $0 |
| **Integrated Family deductible** | $0 | $0 |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Individual Out–of–pocket maximum** | $3,350 | $3,350 |
| **Family Out-of-pocket maximum** | $6,700 | $6,700 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | $15 | | $15 | |
| | Other practitioner office visit | $15 | | $15 | |
| | Specialist visit | $30 | | $30 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| **Tests** | Laboratory Tests | $15 | | $15 | |
| | X-rays and Diagnostic Imaging | $30 | | $30 | |
| | Imaging (CT/PET scans, MRIs) | 10% | | $75 | |
| **Drugs to treat illness or condition** | Tier 1 | $5 | | $5 | |
| | Tier 2 | $15 | | $15 | |
| | Tier 3 | $25 | | $25 | |
| | Tier 4 | 10% up to $250 per script | | 10% up to $250 per script | |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | 10% | | $100 | |
| | Physician/surgeon fees | 10% | | $25 | |
| | Outpatient visit | 10% | | 10% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | $150 | | $150 | |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| | ~~Emergency m~~Medical 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 health, behavioral health, or substance abuse needs** | 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/Behavioral health inpatient physician fee | 10% | | No charge | |
| | 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 | |
| **Pregnancy** | Prenatal care and preconception visits | No charge | | No charge | |
| | Delivery and all inpatient services – Hospital | 10% | | $250 per day up to 5 days | |
| | Delivery and all inpatient services – Professional | 10% | | No charge | |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | 10% | | $20 | |
| | Outpatient Rehabilitation services | $15 | | $15 | |
| | Outpatient Habilitation services | $15 | | $15 | |
| | Skilled nursing care | 10% | | $150 per day up to 5 days | |
| | Durable medical equipment | 10% | | 10% | |
| | Hospice service | No charge | | No charge | |
| **Child eye care** | Eye exam | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | No charge | | No charge | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| **Child Dental Basic Services** | Restorative Procedures | 20% | | See ~~2018~~2019 Dental Copay Schedule | |
| | Periodontal Maintenance Services | | | | |
| **Child Dental Major Services** | Crowns and Casts | 50% | | See ~~2018~~2019 Dental Copay Schedule | |
| | Endodontics | | | | |
| | Periodontics (other than maintenance) | | | | |
| | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| **Child Orthodontics** | Medically necessary orthodontics | 50% | | $1,000 | |

See endnotes.

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

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Gold Coinsurance Plan | Gold Copay Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | 81.8% | ~~78.4%~~78.1% |
| **Plan design includes a deductible?** | No | No |
| **Integrated Individual deductible** | $0 | $0 |
| **Integrated Family deductible** | $0 | $0 |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Individual Out–of–pocket maximum** | ~~$6,000~~$7,200 | ~~$6,000~~$7,200 |
| **Family Out-of-pocket maximum** | ~~$12,000~~$14,400 | ~~$12,000~~$14,400 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Other practitioner office visit | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Specialist visit | | $55 | | $55 | |
| | Preventive care/ screening/ immunization | | No charge | | No charge | |
| **Tests** | Laboratory Tests | | $35 | | $35 | |
| | X-rays and Diagnostic Imaging | | $55 | | $55 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | | $275 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | | $15 | |
| | Tier 2 | | $55 | | $55 | |
| | Tier 3 | | $75 | | $75 | |
| | Tier 4 | | 20% up to $250 per script | | 20% up to $250 per script | |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | | $300 | |
| | Physician/surgeon fees | | 20% | | $40 | |
| | Outpatient visit | | 20% | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $325 | | $325 | |
| | Emergency room physician fee (waived if admitted) | | No charge | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | | $250 | |
| | 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 health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Mental/Behavioral health other outpatient items and services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 20% | | $600 per day up to 5 days | |
| | Mental/Behavioral health inpatient physician fee | | 20% | | No charge | |
| | Substance Use disorder outpatient office visits | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Substance Use disorder other outpatient items and services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 20% | | $600 per day up to 5 days | |
| | Substance use disorder inpatient physician fee | | 20% | | No charge | |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | | $600 per day up to 5 days | |
| | | Professional | 20% | | No charge | |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 20% | | $30 | |
| | Outpatient Rehabilitation services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Outpatient Habilitation services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Skilled nursing care | | 20% | | $300 per day up to 5 days | |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No charge | | No charge | |
| **Child eye care** | Eye exam | | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | No charge | | No charge | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| **Child Dental Basic Services** | Restorative Procedures | | 20% | | See ~~2018~~2019 Dental Copay Schedule | |
| | Periodontal Maintenance Services | | | | | |
| **Child Dental Major Services** | Crowns and Casts | | 50% | | See ~~2018~~2019 Dental Copay Schedule | |
| | Endodontics | | | | | |
| | Periodontics (other than maintenance) | | | | | |
| | Prosthodontics | | | | | |
| | Oral Surgery | | | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | 50% | | $1,000 | |

See endnotes.

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

| 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~~$15,100 |
| **HSA plan: Self-only coverage deductible** | N/A |
| **HSA family plan: Individual deductible** | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | ~~$35~~$40 | |
| | Other practitioner office visit | | ~~$35~~$40 | |
| | Specialist visit | | ~~$75~~$80 | |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | $35 | |
| | X-rays and Diagnostic Imaging | | $75 | |
| | Imaging (CT/PET scans, MRIs) | | $300 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | Pharmacy deductible |
| | Tier 2 | | $55 | Pharmacy deductible |
| | Tier 3 | | $80 | Pharmacy deductible |
| | Tier 4 | | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| | Outpatient visit | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $350 | |
| | Emergency room physician fee (waived if admitted) | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | X |
| | Urgent care | | ~~$35~~$40 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | ~~$35~~$40 | |
| | Mental/Behavioral health other outpatient items and services | | ~~$35~~$40 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 20% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | ~~X~~ |
| | Substance Use disorder outpatient office visits | | ~~$35~~$40 | |
| | Substance Use disorder other outpatient items and services | | ~~$35~~$40 | |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 20% | X |
| | Substance use disorder inpatient physician fee | | 20% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | $45 | |
| | Outpatient Rehabilitation services | | ~~$35~~$40 | |
| | Outpatient Habilitation services | | ~~$35~~$40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No charge | |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | No charge | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | 20% | |
| | Periodontal Maintenance Services | | | |
| **Child Dental Major Services** | Crowns and Casts | | 50% | |
| | Endodontics | | | |
| | Periodontics (other than maintenance) | | | |
| | Prosthodontics | | | |
| | Oral Surgery | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | 50% | |

See endnotes.

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

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | CCSB<br>Silver<br>Coinsurance Plan | CCSB<br>Silver<br>Copay Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | 71.9% | ~~71.4%~~71.6% |
| **Plan design includes a deductible?** | Yes, Medical/Pharmacy | Yes, Medical/Pharmacy |
| **Integrated Individual deductible** | N/A | N/A |
| **Integrated Family deductible** | N/A | N/A |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $2,000 / ~~$125~~$200 / $0 | $2,000 / ~~$125~~$200 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $4,000 / ~~$250~~$400 / $0 | $4,000 / ~~$250~~$400 / $0 |
| **Individual Out–of–pocket maximum** | ~~$7,000~~$7,550 | ~~$7,000~~$7,550 |
| **Family Out-of-pocket maximum** | ~~$14,000~~$15,100 | ~~$14,000~~$15,100 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | $45 | | $45 | |
| | Other practitioner office visit | | $45 | | $45 | |
| | Specialist visit | | ~~$75~~$80 | | ~~$75~~$80 | |
| | Preventive care/ screening/ immunization | | No charge | | No charge | |
| **Tests** | Laboratory Tests | | $40 | | $40 | |
| | X-rays and Diagnostic Imaging | | ~~$70~~$75 | | ~~$70~~$75 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | | $300 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | Pharmacy deductible | $15 | Pharmacy deductible |
| | Tier 2 | | $55 | Pharmacy deductible | $55 | Pharmacy deductible |
| | Tier 3 | | $85 | Pharmacy deductible | $85 | Pharmacy deductible |
| | Tier 4 | | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | | 20% | |
| | Physician/surgeon fees | | 20% | | 20% | |
| | Outpatient visit | | 20% | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $350 | | $350 | |
| | Emergency room physician fee (waived if admitted) | | No charge | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | X | $250 | X |
| | Urgent care | | $45 | | $45 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | X | 20% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | 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% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | X | 20% | ~~X~~ |
| | 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% | X | 20% | X |
| | Substance use disorder inpatient physician fee | | 20% | X | 20% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | X | 20% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 20% | | $45 | |
| | Outpatient Rehabilitation services | | $45 | | $45 | |
| | Outpatient Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No charge | | No charge | |
| **Child eye care** | Eye exam | | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | No charge | | No charge | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| **Child Dental Basic Services** | Restorative Procedures | | 20% | | See ~~2018~~2019 Dental Copay Schedule | |
| | Periodontal Maintenance Services | | | | | |
| **Child Dental Major Services** | Crowns and Casts | | 50% | | See ~~2018~~2019 Dental Copay Schedule | |
| | Endodontics | | | | | |
| | Periodontics (other than maintenance) | | | | | |
| | Prosthodontics | | | | | |
| | Oral Surgery | | | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | 50% | | $1,000 | |

See endnotes.

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

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | CCSB<br>Silver HDHP Plan |
|---|---|
| **Actuarial Value - AV Calculator** | ~~71.7%~~70.5% |
| **Plan design includes a deductible?** | Yes, integrated |
| **Integrated Individual deductible** | ~~$2,000~~$2,500 integrated |
| **Integrated Family deductible** | ~~$4,000~~$5,000 integrated |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Individual Out–of–pocket maximum** | ~~$6,550~~$6,650 |
| **Family Out-of-pocket maximum** | ~~$13,100~~$13,300 |
| **HSA plan: Self-only coverage deductible** | ~~$2,000~~$2,500 |
| **HSA family plan: Individual deductible** | $2,700 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | 20% | X |
| | Other practitioner office visit | | 20% | X |
| | Specialist visit | | 20% | X |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | 20% | X |
| | X-rays and Diagnostic Imaging | | 20% | X |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| **Drugs to treat illness or condition** | Tier 1 | | 20% up to $250 per script | X |
| | Tier 2 | | 20% up to $250 per script | X |
| | Tier 3 | | 20% up to $250 per script | X |
| | Tier 4 | | 20% up to $250 per script | X |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | X |
| | Physician/surgeon fees | | 20% | X |
| | Outpatient visit | | 20% | X |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | 20% | X |
| | Emergency room physician fee (waived if admitted) | | 0% | X |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | 20% | X |
| | Urgent care | | 20% | X |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | 20% | X |
| | Mental/Behavioral health other outpatient items and services | | 20% | X |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 20% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | X |
| | Substance Use disorder outpatient office visits | | 20% | X |
| | Substance Use disorder other outpatient items and services | | 20% | X |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 20% | X |
| | Substance use disorder inpatient physician fee | | 20% | X |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | X |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 20% | X |
| | Outpatient Rehabilitation services | | 20% | X |
| | Outpatient Habilitation services | | 20% | X |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | X |
| | Hospice service | | 0% | X |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | No charge | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | 20% | |
| | Periodontal Maintenance Services | | | |
| **Child Dental Major Services** | Crowns and Casts | | 50% | |
| | Endodontics | | | |
| | Periodontics (other than maintenance) | | | |
| | Prosthodontics | | | |
| | Oral Surgery | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | 50% | |

See endnotes.

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

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Plan 100%-150% FPL | Silver Plan 150%-200% FPL |
|---|---|---|
| **Actuarial Value - AV Calculator** | ~~93.9%~~94.2% | ~~88.0%~~87.9% |
| **Plan design includes a deductible?** | Yes, Medical/Pharmacy | Yes, Medical/Pharmacy |
| **Integrated Individual deductible** | N/A | N/A |
| **Integrated Family deductible** | N/A | N/A |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $75 / $0 / $0 | $650 / $50 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $150 / $0 / $0 | $1,300 / $100 / $0 |
| **Individual Out–of–pocket maximum** | $1,000 | ~~$2,450~~$2,600 |
| **Family Out-of-pocket maximum** | $2,000 | ~~$4,900~~$5,200 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | $5 | | ~~$10~~$15 | |
| | Other practitioner office visit | $5 | | ~~$10~~$15 | |
| | Specialist visit | $8 | | $25 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| **Tests** | Laboratory Tests | $8 | | $15 | |
| | X-rays and Diagnostic Imaging | $8 | | ~~$25~~$30 | |
| | Imaging (CT/PET scans, MRIs) | $50 | | $100 | |
| **Drugs to treat illness or condition** | Tier 1 | $3 | | $5 | |
| | Tier 2 | $10 | | $20 | Pharmacy deductible |
| | Tier 3 | $15 | | $35 | Pharmacy deductible |
| | Tier 4 | 10% up to $150 per script | | 15% up to $150 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | 10% | | 15% | |
| | Physician/surgeon fees | 10% | | 15% | |
| | Outpatient visit | 10% | | 15% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | $50 | | $100 | |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | $30 | X | $75 | X |
| | Urgent care | $5 | | ~~$10~~$15 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | 10% | X | 15% | X |
| | Physician/surgeon fee | 10% | ~~X~~ | 15% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | $5 | | ~~$10~~$15 | |
| | Mental/Behavioral health other outpatient items and services | $5 | | ~~$10~~$15 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | 10% | X | 15% | X |
| | Mental/Behavioral health inpatient physician fee | 10% | ~~X~~ | 15% | ~~X~~ |
| | Substance Use disorder outpatient office visits | $5 | | ~~$10~~$15 | |
| | Substance Use disorder other outpatient items and services | $5 | | ~~$10~~$15 | |
| | Substance Use inpatient facility fee (e.g. hospital room) | 10% | X | 15% | X |
| | Substance use disorder inpatient physician fee | 10% | ~~X~~ | 15% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | No charge | | No charge | |
| | Delivery and all inpatient services – Hospital | 10% | X | 15% | X |
| | Delivery and all inpatient services – Professional | 10% | ~~X~~ | 15% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | $3 | | $15 | |
| | Outpatient Rehabilitation services | $5 | | ~~$10~~$15 | |
| | Outpatient Habilitation services | $5 | | ~~$10~~$15 | |
| | Skilled nursing care | 10% | X | 15% | X |
| | Durable medical equipment | 10% | | 15% | |
| | Hospice service | No charge | | No charge | |
| **Child eye care** | Eye exam | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | No charge | | No charge | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| **Child Dental Basic Services** | Restorative Procedures | 20% | | 20% | |
| | Periodontal Maintenance Services | | | | |
| **Child Dental Major Services** | Crowns and Casts | 50% | | 50% | |
| | Endodontics | | | | |
| | Periodontics (other than maintenance) | | | | |
| | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| **Child Orthodontics** | Medically necessary orthodontics | 50% | | 50% | |

See endnotes.

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

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Plan 200%-250% FPL |
|---|---|
| **Actuarial Value - AV Calculator** | 73.9% |
| | |
| **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** | $2,200 / ~~$130~~$175 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $4,400 / ~~$260~~$350 / $0 |
| **Individual Out–of–pocket maximum** | ~~$5,850~~$6,300 |
| **Family Out-of-pocket maximum** | ~~$11,700~~$12,600 |
| **HSA plan: Self-only coverage deductible** | N/A |
| **HSA family plan: Individual deductible** | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | ~~$30~~$35 | |
| | Other practitioner office visit | | ~~$30~~$35 | |
| | Specialist visit | | $75 | |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | $35 | |
| | X-rays and Diagnostic Imaging | | $75 | |
| | Imaging (CT/PET scans, MRIs) | | $300 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | Pharmacy deductible |
| | Tier 2 | | $50 | Pharmacy deductible |
| | Tier 3 | | $75 | Pharmacy deductible |
| | Tier 4 | | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| | Outpatient visit | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $350 | |
| | Emergency room physician fee (waived if admitted) | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | X |
| | Urgent care | | ~~$30~~$35 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | 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% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | ~~X~~ |
| | 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% | X |
| | Substance use disorder inpatient physician fee | | 20% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | $40 | |
| | Outpatient Rehabilitation services | | ~~$30~~$35 | |
| | Outpatient Habilitation services | | ~~$30~~$35 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No charge | |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | No charge | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | 20% | |
| | Periodontal Maintenance Services | | | |
| **Child Dental Major Services** | Crowns and Casts | | 50% | |
| | Endodontics | | | |
| | Periodontics (other than maintenance) | | | |
| | Prosthodontics | | | |
| | Oral Surgery | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | 50% | |

See endnotes.

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

### Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Bronze Plan | Bronze HDHP Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | ~~60.8%~~60.9% | ~~61.4%~~61.6% |
| **Plan design includes a deductible?** | Yes, Medical/Pharmacy | Yes, integrated |
| **Integrated Individual deductible** | N/A | ~~$4,800~~$6,000 integrated |
| **Integrated Family deductible** | N/A | ~~$9,600~~$12,000 integrated |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $6,300 / $500 / $0 | N/A |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $12,600 / $1,000 / $0 | N/A |
| **Individual Out–of–pocket maximum** | ~~$7,000~~$7,550 | ~~$6,550~~$6,650 |
| **Family Out-of-pocket maximum** | ~~$14,000~~$15,100 | ~~$13,100~~$13,300 |
| **HSA plan: Self-only coverage deductible** | N/A | $4,800 |
| **HSA family plan: Individual deductible** | N/A | $4,800 |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | $75 | After 1st three non-preventive visits | 40% | X |
| | Other practitioner office visit | $75 | After 1st three non-preventive visits | 40% | X |
| | Specialist visit | $105 | After 1st three non-preventive visits | 40% | X |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| **Tests** | Laboratory Tests | $40 | | 40% | X |
| | X-rays and Diagnostic Imaging | 100% | X | 40% | X |
| | Imaging (CT/PET scans, MRIs) | 100% | X | 40% | X |
| **Drugs to treat illness or condition** | Tier 1 | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| | Tier 2 | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| | Tier 3 | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| | Tier 4 | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | 100% | X | 40% | X |
| | Physician/surgeon fees | 100% | X | 40% | X |
| | Outpatient visit | 100% | X | 40% | X |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | 100% | X | 40% | X |
| | Emergency room physician fee (waived if admitted) | No charge | | 0% | X |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | 100% | X | 40% | X |
| | Urgent care | $75 | After 1st three non-preventive visits | 40% | X |
| **Hospital stay** | Facility fee (e.g. hospital room) | 100% | X | 40% | X |
| | Physician/surgeon fee | 100% | X | 40% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | $75 | After 1st three non-preventive visits | 40% | X |
| | Mental/Behavioral health other outpatient items and services | $75 | X | 40% | X |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | 100% | X | 40% | X |
| | Mental/Behavioral health inpatient physician fee | 100% | X | 40% | X |
| | Substance Use disorder outpatient office visits | $75 | After 1st three non-preventive visits | 40% | X |
| | Substance Use disorder other outpatient items and services | $75 | X | 40% | X |
| | Substance Use inpatient facility fee (e.g. hospital room) | 100% | X | 40% | X |
| | Substance use disorder inpatient physician fee | 100% | X | 40% | X |
| **Pregnancy** | Prenatal care and preconception visits | No charge | | No charge | |
| | Delivery and all inpatient services – Hospital | 100% | X | 40% | X |
| | Delivery and all inpatient services – Professional | 100% | X | 40% | X |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | 100% | X | 40% | X |
| | Outpatient Rehabilitation services | $75 | | 40% | X |
| | Outpatient Habilitation services | $75 | | 40% | X |
| | Skilled nursing care | 100% | X | 40% | X |
| | Durable medical equipment | 100% | X | 40% | X |
| | Hospice service | No charge | | 0% | X |
| **Child eye care** | Eye exam | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | No charge | | No charge | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| **Child Dental Basic Services** | Restorative Procedures | 20% | | 20% | |
| | Periodontal Maintenance Services | | | | |
| **Child Dental Major Services** | Crowns and Casts | 50% | | 50% | |
| | Endodontics | | | | |
| | Periodontics (other than maintenance) | | | | |
| | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| **Child Orthodontics** | Medically necessary orthodontics | 50% | | 50% | |

See endnotes.

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

**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~~$7,900 integrated |
| **Integrated Family deductible** | ~~$14,700~~$15,800 integrated |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Individual Out–of–pocket maximum** | ~~$7,350~~$7,900 |
| **Family Out-of-pocket maximum** | ~~$14,700~~$15,800 |
| **HSA plan: Self-only coverage deductible** | N/A |
| **HSA family plan: Individual deductible** | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | 0% | After 1st three non-preventive visits |
| | Other practitioner office visit | | 0% | After 1st three non-preventive visits |
| | Specialist visit | | 0% | X |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | 0% | X |
| | X-rays and Diagnostic Imaging | | 0% | X |
| | Imaging (CT/PET scans, MRIs) | | 0% | X |
| **Drugs to treat illness or condition** | Tier 1 | | 0% | X |
| | Tier 2 | | 0% | X |
| | Tier 3 | | 0% | X |
| | Tier 4 | | 0% | X |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 0% | X |
| | Physician/surgeon fees | | 0% | X |
| | Outpatient visit | | 0% | X |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | 0% | X |
| | Emergency room physician fee (waived if admitted) | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | 0% | X |
| | Urgent care | | 0% | After 1st three non-preventive visits |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 0% | X |
| | Physician/surgeon fee | | 0% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | 0% | After 1st three non-preventive visits |
| | Mental/Behavioral health other outpatient items and services | | 0% | X |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 0% | X |
| | Mental/Behavioral health inpatient physician fee | | 0% | X |
| | Substance Use disorder outpatient office visits | | 0% | After 1st three non-preventive visits |
| | Substance Use disorder other outpatient items and services | | 0% | X |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 0% | X |
| | Substance use disorder inpatient physician fee | | 0% | X |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 0% | X |
| | | Professional | 0% | X |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 0% | X |
| | Outpatient Rehabilitation services | | 0% | X |
| | Outpatient Habilitation services | | 0% | X |
| | Skilled nursing care | | 0% | X |
| | Durable medical equipment | | 0% | X |
| | Hospice service | | 0% | X |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | 0% | X |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | No charge | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | 0% | X |
| | Periodontal Maintenance Services | | | X |
| **Child Dental Major Services** | Crowns and Casts | | 0% | X |
| | Endodontics | | | X |
| | Periodontics (other than maintenance) | | | X |
| | Prosthodontics | | | X |
| | Oral Surgery | | | X |
| **Child Orthodontics** | Medically necessary orthodontics | | 0% | X |

See endnotes.

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

## Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

| | Platinum Coinsurance Plan | Platinum Copay Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | ~~91.2%~~91.7% | ~~88.1%~~88.9% |
| **Plan design includes a deductible?** | No | No |
| **Integrated Individual deductible** | $0 | $0 |
| **Integrated Family deductible** | $0 | $0 |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Individual Out–of–pocket maximum** | $3,350 | $3,350 |
| **Family Out-of-pocket maximum** | $6,700 | $6,700 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | $15 | | $15 | |
| | Other practitioner office visit | $15 | | $15 | |
| | Specialist visit | $30 | | $30 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| **Tests** | Laboratory Tests | $15 | | $15 | |
| | X-rays and Diagnostic Imaging | $30 | | $30 | |
| | Imaging (CT/PET scans, MRIs) | 10% | | $75 | |
| **Drugs to treat illness or condition** | Tier 1 | $5 | | $5 | |
| | Tier 2 | $15 | | $15 | |
| | Tier 3 | $25 | | $25 | |
| | Tier 4 | 10% up to $250 per script | | 10% up to $250 per script | |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | 10% | | $100 | |
| | Physician/surgeon fees | 10% | | $25 | |
| | Outpatient visit | 10% | | 10% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | $150 | | $150 | |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| | ~~Emergency m~~Medical 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 health, behavioral health, or substance abuse needs** | 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/Behavioral health inpatient physician fee | 10% | | No charge | |
| | 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 | |
| **Pregnancy** | Prenatal care and preconception visits | No charge | | No charge | |
| | Delivery and all inpatient services – Hospital | 10% | | $250 per day up to 5 days | |
| | Delivery and all inpatient services – Professional | 10% | | No charge | |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | 10% | | $20 | |
| | Outpatient Rehabilitation services | $15 | | $15 | |
| | Outpatient Habilitation services | $15 | | $15 | |
| | Skilled nursing care | 10% | | $150 per day up to 5 days | |
| | Durable medical equipment | 10% | | 10% | |
| | Hospice service | No charge | | No charge | |
| **Child eye care** | Eye exam | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| **Child Dental Basic Services** | Restorative Procedures | Not Covered | | Not Covered | |
| | Periodontal Maintenance Services | | | | |
| **Child Dental Major Services** | Crowns and Casts | Not Covered | | Not Covered | |
| | Endodontics | | | Not Covered | |
| | Periodontics (other than maintenance) | | | Not Covered | |
| | Prosthodontics | | | Not Covered | |
| | Oral Surgery | | | Not Covered | |
| **Child Orthodontics** | Medically necessary orthodontics | Not Covered | | Not Covered | |

See endnotes.

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

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Gold Coinsurance Plan | Gold Copay Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | 81.8% | ~~78.4%~~78.1% |
| **Plan design includes a deductible?** | No | No |
| **Integrated Individual deductible** | $0 | $0 |
| **Integrated Family deductible** | $0 | $0 |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $0 / $0 / $0 | $0 / $0 / $0 |
| **Individual Out–of–pocket maximum** | ~~$6,000~~$7,200 | ~~$6,000~~$7,200 |
| **Family Out-of-pocket maximum** | ~~$12,000~~$14,400 | ~~$12,000~~$14,400 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Other practitioner office visit | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Specialist visit | | $55 | | $55 | |
| | Preventive care/ screening/ immunization | | No charge | | No charge | |
| **Tests** | Laboratory Tests | | $35 | | $35 | |
| | X-rays and Diagnostic Imaging | | $55 | | $55 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | | $275 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | | $15 | |
| | Tier 2 | | $55 | | $55 | |
| | Tier 3 | | $75 | | $75 | |
| | Tier 4 | | 20% up to $250 per script | | 20% up to $250 per script | |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | | $300 | |
| | Physician/surgeon fees | | 20% | | $40 | |
| | Outpatient visit | | 20% | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $325 | | $325 | |
| | Emergency room physician fee (waived if admitted) | | No charge | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | | $250 | |
| | 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 health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Mental/Behavioral health other outpatient items and services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 20% | | $600 per day up to 5 days | |
| | Mental/Behavioral health inpatient physician fee | | 20% | | No charge | |
| | Substance Use disorder outpatient office visits | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Substance Use disorder other outpatient items and services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 20% | | $600 per day up to 5 days | |
| | Substance use disorder inpatient physician fee | | 20% | | No charge | |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | | $600 per day up to 5 days | |
| | | Professional | 20% | | No charge | |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 20% | | $30 | |
| | Outpatient Rehabilitation services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Outpatient Habilitation services | | ~~$25~~$30 | | ~~$25~~$30 | |
| | Skilled nursing care | | 20% | | $300 per day up to 5 days | |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No charge | | No charge | |
| **Child eye care** | Eye exam | | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| **Child Dental Basic Services** | Restorative Procedures | | Not Covered | | Not Covered | |
| | Periodontal Maintenance Services | | | | | |
| **Child Dental Major Services** | Crowns and Casts | | Not Covered | | Not Covered | |
| | Endodontics | | | | Not Covered | |
| | Periodontics (other than maintenance) | | | | Not Covered | |
| | Prosthodontics | | | | Not Covered | |
| | Oral Surgery | | | | Not Covered | |
| **Child Orthodontics** | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

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

| 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~~$15,100 |
| **HSA plan: Self-only coverage deductible** | N/A |
| **HSA family plan: Individual deductible** | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | ~~$35~~$40 | |
| | Other practitioner office visit | | ~~$35~~$40 | |
| | Specialist visit | | ~~$75~~$80 | |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | $35 | |
| | X-rays and Diagnostic Imaging | | $75 | |
| | Imaging (CT/PET scans, MRIs) | | $300 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | Pharmacy deductible |
| | Tier 2 | | $55 | Pharmacy deductible |
| | Tier 3 | | ~~$80~~$90 | Pharmacy deductible |
| | Tier 4 | | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| | Outpatient visit | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $350 | |
| | Emergency room physician fee (waived if admitted) | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | X |
| | Urgent care | | ~~$35~~$40 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | ~~$35~~$40 | |
| | Mental/Behavioral health other outpatient items and services | | ~~$35~~$40 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 20% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | ~~X~~ |
| | Substance Use disorder outpatient office visits | | ~~$35~~$40 | |
| | Substance Use disorder other outpatient items and services | | ~~$35~~$40 | |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 20% | X |
| | Substance use disorder inpatient physician fee | | 20% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | $45 | |
| | Outpatient Rehabilitation services | | ~~$35~~$40 | |
| | Outpatient Habilitation services | | ~~$35~~$40 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No charge | |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | Not Covered | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | Not Covered | |
| | Periodontal Maintenance Services | | | |
| **Child Dental Major Services** | Crowns and Casts | | Not Covered | |
| | Endodontics | | | |
| | Periodontics (other than maintenance) | | | |
| | Prosthodontics | | | |
| | Oral Surgery | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | Not Covered | |

See endnotes.

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

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | CCSB<br>Silver<br>Coinsurance Plan | CCSB<br>Silver<br>Copay Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | 71.9% | ~~71.4%~~71.6% |
| **Plan design includes a deductible?** | Yes, Medical/Pharmacy | Yes, Medical/Pharmacy |
| **Integrated Individual deductible** | N/A | N/A |
| **Integrated Family deductible** | N/A | N/A |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $2,000 / ~~$125~~$200 / $0 | $2,000 / ~~$125~~$200 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $4,000 / ~~$250~~$400 / $0 | $4,000 / ~~$250~~$400 / $0 |
| **Individual Out–of–pocket maximum** | ~~$7,000~~$7,550 | ~~$7,000~~$7,550 |
| **Family Out-of-pocket maximum** | ~~$14,000~~$15,100 | ~~$14,000~~$15,100 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | $45 | | $45 | |
| | Other practitioner office visit | | $45 | | $45 | |
| | Specialist visit | | ~~$75~~$80 | | ~~$75~~$80 | |
| | Preventive care/ screening/ immunization | | No charge | | No charge | |
| **Tests** | Laboratory Tests | | $40 | | $40 | |
| | X-rays and Diagnostic Imaging | | ~~$70~~$75 | | ~~$70~~$75 | |
| | Imaging (CT/PET scans, MRIs) | | 20% | | $300 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | Pharmacy deductible | $15 | Pharmacy deductible |
| | Tier 2 | | $55 | Pharmacy deductible | $55 | Pharmacy deductible |
| | Tier 3 | | $85 | Pharmacy deductible | $85 | Pharmacy deductible |
| | Tier 4 | | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | | 20% | |
| | Physician/surgeon fees | | 20% | | 20% | |
| | Outpatient visit | | 20% | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $350 | | $350 | |
| | Emergency room physician fee (waived if admitted) | | No charge | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | X | $250 | X |
| | Urgent care | | $45 | | $45 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X | 20% | X |
| | Physician/surgeon fee | | 20% | X | 20% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | 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% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | X | 20% | ~~X~~ |
| | 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% | X | 20% | X |
| | Substance use disorder inpatient physician fee | | 20% | X | 20% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X | 20% | X |
| | | Professional | 20% | X | 20% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 20% | | $45 | |
| | Outpatient Rehabilitation services | | $45 | | $45 | |
| | Outpatient Habilitation services | | $45 | | $45 | |
| | Skilled nursing care | | 20% | X | 20% | X |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service | | No charge | | No charge | |
| **Child eye care** | Eye exam | | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| **Child Dental Basic Services** | Restorative Procedures | | Not Covered | | Not Covered | |
| | Periodontal Maintenance Services | | | | | |
| **Child Dental Major Services** | Crowns and Casts | | Not Covered | | Not Covered | |
| | Endodontics | | | | Not Covered | |
| | Periodontics (other than maintenance) | | | | Not Covered | |
| | Prosthodontics | | | | Not Covered | |
| | Oral Surgery | | | | Not Covered | |
| **Child Orthodontics** | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

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

| Summary of Benefits and Coverage<br>Member Cost Share amounts describe the Enrollee's out of pocket costs. | CCSB<br>Silver HDHP Plan |
|---|---|
| **Actuarial Value - AV Calculator** | ~~71.7%~~70.5% |
| **Plan design includes a deductible?** | Yes, integrated |
| **Integrated Individual deductible** | ~~$2,000~~$2,500 integrated |
| **Integrated Family deductible** | ~~$4,000~~$5,000 integrated |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Individual Out–of–pocket maximum** | ~~$6,550~~$6,650 |
| **Family Out-of-pocket maximum** | ~~$13,100~~$13,300 |
| **HSA plan: Self-only coverage deductible** | ~~$2,000~~$2,500 |
| **HSA family plan: Individual deductible** | $2,700 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | 20% | X |
| | Other practitioner office visit | | 20% | X |
| | Specialist visit | | 20% | X |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | 20% | X |
| | X-rays and Diagnostic Imaging | | 20% | X |
| | Imaging (CT/PET scans, MRIs) | | 20% | X |
| **Drugs to treat illness or condition** | Tier 1 | | 20% up to $250 per script | X |
| | Tier 2 | | 20% up to $250 per script | X |
| | Tier 3 | | 20% up to $250 per script | X |
| | Tier 4 | | 20% up to $250 per script | X |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | X |
| | Physician/surgeon fees | | 20% | X |
| | Outpatient visit | | 20% | X |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | 20% | X |
| | Emergency room physician fee (waived if admitted) | | 0% | X |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | 20% | X |
| | Urgent care | | 20% | X |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | 20% | X |
| | Mental/Behavioral health other outpatient items and services | | 20% | X |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 20% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | X |
| | Substance Use disorder outpatient office visits | | 20% | X |
| | Substance Use disorder other outpatient items and services | | 20% | X |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 20% | X |
| | Substance use disorder inpatient physician fee | | 20% | X |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | X |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 20% | X |
| | Outpatient Rehabilitation services | | 20% | X |
| | Outpatient Habilitation services | | 20% | X |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | X |
| | Hospice service | | 0% | X |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | Not Covered | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | Not Covered | |
| | Periodontal Maintenance Services | | | |
| **Child Dental Major Services** | Crowns and Casts | | Not Covered | |
| | Endodontics | | | |
| | Periodontics (other than maintenance) | | | |
| | Prosthodontics | | | |
| | Oral Surgery | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | Not Covered | |

See endnotes.

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

**Summary of Benefits and Coverage**

Member Cost Share amounts describe the Enrollee's out of pocket costs.

| | Silver Plan 100%-150% FPL | Silver Plan 150%-200% FPL |
|---|---|---|
| **Actuarial Value - AV Calculator** | ~~93.9%~~94.2% | ~~88.0%~~87.9% |
| **Plan design includes a deductible?** | Yes, Medical/Pharmacy | Yes, Medical/Pharmacy |
| **Integrated Individual deductible** | N/A | N/A |
| **Integrated Family deductible** | N/A | N/A |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $75 / $0 / $0 | $650 / $50 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $150 / $0 / $0 | $1,300 / $100 / $0 |
| **Individual Out–of–pocket maximum** | $1,000 | ~~$2,450~~$2,600 |
| **Family Out-of-pocket maximum** | $2,000 | ~~$4,900~~$5,200 |
| **HSA plan: Self-only coverage deductible** | N/A | N/A |
| **HSA family plan: Individual deductible** | N/A | N/A |

| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | $5 | | ~~$10~~$15 | |
| | Other practitioner office visit | $5 | | ~~$10~~$15 | |
| | Specialist visit | $8 | | $25 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| **Tests** | Laboratory Tests | $8 | | $15 | |
| | X-rays and Diagnostic Imaging | $8 | | ~~$25~~$30 | |
| | Imaging (CT/PET scans, MRIs) | $50 | | $100 | |
| **Drugs to treat illness or condition** | Tier 1 | $3 | | $5 | |
| | Tier 2 | $10 | | $20 | Pharmacy deductible |
| | Tier 3 | $15 | | $35 | Pharmacy deductible |
| | Tier 4 | 10% up to $150 per script | | 15% up to $150 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | 10% | | 15% | |
| | Physician/surgeon fees | 10% | | 15% | |
| | Outpatient visit | 10% | | 15% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | $50 | | $100 | |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | $30 | X | $75 | X |
| | Urgent care | $5 | | ~~$10~~$15 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | 10% | X | 15% | X |
| | Physician/surgeon fee | 10% | ~~X~~ | 15% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | $5 | | ~~$10~~$15 | |
| | Mental/Behavioral health other outpatient items and services | $5 | | ~~$10~~$15 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | 10% | X | 15% | X |
| | Mental/Behavioral health inpatient physician fee | 10% | X | 15% | ~~X~~ |
| | Substance Use disorder outpatient office visits | $5 | | ~~$10~~$15 | |
| | Substance Use disorder other outpatient items and services | $5 | | ~~$10~~$15 | |
| | Substance Use inpatient facility fee (e.g. hospital room) | 10% | X | 15% | X |
| | Substance use disorder inpatient physician fee | 10% | X | 15% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | No charge | | No charge | |
| | Delivery and all inpatient services – Hospital | 10% | X | 15% | X |
| | Delivery and all inpatient services – Professional | 10% | X | 15% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | $3 | | $15 | |
| | Outpatient Rehabilitation services | $5 | | ~~$10~~$15 | |
| | Outpatient Habilitation services | $5 | | ~~$10~~$15 | |
| | Skilled nursing care | 10% | X | 15% | X |
| | Durable medical equipment | 10% | | 15% | |
| | Hospice service | No charge | | No charge | |
| **Child eye care** | Eye exam | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | |
| | Preventive - X-ray | | | | |
| | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| **Child Dental Basic Services** | Restorative Procedures | Not Covered | | Not Covered | |
| | Periodontal Maintenance Services | | | | |
| **Child Dental Major Services** | Crowns and Casts | Not Covered | | Not Covered | |
| | Endodontics | | | | |
| | Periodontics (other than maintenance) | | | | |
| | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| **Child Orthodontics** | Medically necessary orthodontics | Not Covered | | Not Covered | |

See endnotes.

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

**Summary of Benefits and Coverage**

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Silver Plan 200%-250% FPL |
|---|---|
| **Actuarial Value - AV Calculator** | 73.9% |
| | |
| **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** | $2,200 / ~~$130~~$175 / $0 |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $4,400 / ~~$260~~$350 / $0 |
| **Individual Out–of–pocket maximum** | ~~$5,850~~$6,300 |
| **Family Out-of-pocket maximum** | ~~$11,700~~$12,600 |
| **HSA plan: Self-only coverage deductible** | N/A |
| **HSA family plan: Individual deductible** | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | ~~$30~~$35 | |
| | Other practitioner office visit | | ~~$30~~$35 | |
| | Specialist visit | | $75 | |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | $35 | |
| | X-rays and Diagnostic Imaging | | $75 | |
| | Imaging (CT/PET scans, MRIs) | | $300 | |
| **Drugs to treat illness or condition** | Tier 1 | | $15 | Pharmacy deductible |
| | Tier 2 | | $50 | Pharmacy deductible |
| | Tier 3 | | $75 | Pharmacy deductible |
| | Tier 4 | | 20% up to $250 per script after pharmacy deductible | Pharmacy deductible |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 20% | |
| | Physician/surgeon fees | | 20% | |
| | Outpatient visit | | 20% | |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | $350 | |
| | Emergency room physician fee (waived if admitted) | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | $250 | X |
| | Urgent care | | ~~$30~~$35 | |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 20% | X |
| | Physician/surgeon fee | | 20% | ~~X~~ |
| **Mental health, behavioral health, or substance abuse needs** | 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% | X |
| | Mental/Behavioral health inpatient physician fee | | 20% | ~~X~~ |
| | 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% | X |
| | Substance use disorder inpatient physician fee | | 20% | ~~X~~ |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 20% | X |
| | | Professional | 20% | ~~X~~ |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | $40 | |
| | Outpatient Rehabilitation services | | ~~$30~~$35 | |
| | Outpatient Habilitation services | | ~~$30~~$35 | |
| | Skilled nursing care | | 20% | X |
| | Durable medical equipment | | 20% | |
| | Hospice service | | No charge | |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | Not Covered | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | Not Covered | |
| | Periodontal Maintenance Services | | | |
| **Child Dental Major Services** | Crowns and Casts | | Not Covered | |
| | Endodontics | | | |
| | Periodontics (other than maintenance) | | | |
| | Prosthodontics | | | |
| | Oral Surgery | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | Not Covered | |

See endnotes.

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

### Summary of Benefits and Coverage

| Member Cost Share amounts describe the Enrollee's out of pocket costs. | Bronze Plan | Bronze HDHP Plan |
|---|---|---|
| **Actuarial Value - AV Calculator** | ~~60.8%~~60.9% | ~~61.4%~~61.6% |
| **Plan design includes a deductible?** | Yes, Medical/Pharmacy | Yes, integrated |
| **Integrated Individual deductible** | N/A | ~~$4,800~~$6,000 integrated |
| **Integrated Family deductible** | N/A | ~~$9,600~~$12,000 integrated |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | $6,300 / $500 / $0 | N/A |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | $12,600 / $1,000 / $0 | N/A |
| **Individual Out–of–pocket maximum** | ~~$7,000~~$7,550 | ~~$6,550~~$6,650 |
| **Family Out-of-pocket maximum** | ~~$14,000~~$15,100 | ~~$13,100~~$13,300 |
| **HSA plan: Self-only coverage deductible** | N/A | $4,800 |
| **HSA family plan: Individual deductible** | N/A | $4,800 |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
|---|---|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | $75 | After 1st three non-preventive visits | 40% | X |
| | Other practitioner office visit | | $75 | After 1st three non-preventive visits | 40% | X |
| | Specialist visit | | $105 | After 1st three non-preventive visits | 40% | X |
| | Preventive care/ screening/ immunization | | No charge | | No charge | |
| **Tests** | Laboratory Tests | | $40 | | 40% | X |
| | X-rays and Diagnostic Imaging | | 100% | X | 40% | X |
| | Imaging (CT/PET scans, MRIs) | | 100% | X | 40% | X |
| **Drugs to treat illness or condition** | Tier 1 | | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| | Tier 2 | | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| | Tier 3 | | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| | Tier 4 | | 100% up to $500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to $500 per script | X |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 100% | X | 40% | X |
| | Physician/surgeon fees | | 100% | X | 40% | X |
| | Outpatient visit | | 100% | X | 40% | X |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | 100% | X | 40% | X |
| | Emergency room physician fee (waived if admitted) | | No charge | | 0% | X |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | 100% | X | 40% | X |
| | Urgent care | | $75 | After 1st three non-preventive visits | 40% | X |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 100% | X | 40% | X |
| | Physician/surgeon fee | | 100% | X | 40% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | $75 | After 1st three non-preventive visits | 40% | X |
| | Mental/Behavioral health other outpatient items and services | | $75 | X | 40% | X |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 100% | X | 40% | X |
| | Mental/Behavioral health inpatient physician fee | | 100% | X | 40% | X |
| | Substance Use disorder outpatient office visits | | $75 | After 1st three non-preventive visits | 40% | X |
| | Substance Use disorder other outpatient items and services | | $75 | X | 40% | X |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 100% | X | 40% | X |
| | Substance use disorder inpatient physician fee | | 100% | X | 40% | X |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | | No charge | |
| | Delivery and all inpatient services | Hospital | 100% | X | 40% | X |
| | | Professional | 100% | X | 40% | X |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 100% | X | 40% | X |
| | Outpatient Rehabilitation services | | $75 | | 40% | X |
| | Outpatient Habilitation services | | $75 | | 40% | X |
| | Skilled nursing care | | 100% | X | 40% | X |
| | Durable medical equipment | | 100% | X | 40% | X |
| | Hospice service | | No charge | | 0% | X |
| **Child eye care** | Eye exam | | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | No charge | | No charge | |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | Not Covered | | Not Covered | |
| | Preventive - Cleaning | | | | | |
| | Preventive - X-ray | | | | | |
| | Sealants per Tooth | | | | | |
| | Topical Fluoride Application | | | | | |
| | Space Maintainers - Fixed | | | | | |
| **Child Dental Basic Services** | Restorative Procedures | | Not Covered | | Not Covered | |
| | Periodontal Maintenance Services | | | | | |
| **Child Dental Major Services** | Crowns and Casts | | Not Covered | | Not Covered | |
| | Endodontics | | | | | |
| | Periodontics (other than maintenance) | | | | | |
| | Prosthodontics | | | | | |
| | Oral Surgery | | | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | Not Covered | | Not Covered | |

See endnotes.

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

**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~~$7,900 integrated |
| **Integrated Family deductible** | ~~$14,700~~$15,800 integrated |
| **Individual deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Family deductible, NOT integrated: Medical / Pharmacy / Dental** | N/A |
| **Individual Out–of–pocket maximum** | ~~$7,350~~$7,900 |
| **Family Out-of-pocket maximum** | ~~$14,700~~$15,800 |
| **HSA plan: Self-only coverage deductible** | N/A |
| **HSA family plan: Individual deductible** | N/A |

| Common Medical Event | Service Type | | Member Cost Share | Deductible Applies |
|---|---|---|---|---|
| **Health care provider's office or clinic visit** | Primary care visit to treat an injury, illness, or condition | | 0% | After 1st three non-preventive visits |
| | Other practitioner office visit | | 0% | After 1st three non-preventive visits |
| | Specialist visit | | 0% | X |
| | Preventive care/ screening/ immunization | | No charge | |
| **Tests** | Laboratory Tests | | 0% | X |
| | X-rays and Diagnostic Imaging | | 0% | X |
| | Imaging (CT/PET scans, MRIs) | | 0% | X |
| **Drugs to treat illness or condition** | Tier 1 | | 0% | X |
| | Tier 2 | | 0% | X |
| | Tier 3 | | 0% | X |
| | Tier 4 | | 0% | X |
| **Outpatient services** | Surgery facility fee (e.g., ASC) | | 0% | X |
| | Physician/surgeon fees | | 0% | X |
| | Outpatient visit | | 0% | X |
| **Need immediate attention** | Emergency room facility fee (waived if admitted) | | 0% | X |
| | Emergency room physician fee (waived if admitted) | | No charge | |
| | ~~Emergency m~~Medical transportation (including emergency and non-emergency) | | 0% | X |
| | Urgent care | | 0% | After 1st three non-preventive visits |
| **Hospital stay** | Facility fee (e.g. hospital room) | | 0% | X |
| | Physician/surgeon fee | | 0% | X |
| **Mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient office visits | | 0% | After 1st three non-preventive visits |
| | Mental/Behavioral health other outpatient items and services | | 0% | X |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 0% | X |
| | Mental/Behavioral health inpatient physician fee | | 0% | X |
| | Substance Use disorder outpatient office visits | | 0% | After 1st three non-preventive visits |
| | Substance Use disorder other outpatient items and services | | 0% | X |
| | Substance Use inpatient facility fee (e.g. hospital room) | | 0% | X |
| | Substance use disorder inpatient physician fee | | 0% | X |
| **Pregnancy** | Prenatal care and preconception visits | | No charge | |
| | Delivery and all inpatient services | Hospital | 0% | X |
| | | Professional | 0% | X |
| **Help recovering or other special health needs** | Home health care (cost share per visit) | | 0% | X |
| | Outpatient Rehabilitation services | | 0% | X |
| | Outpatient Habilitation services | | 0% | X |
| | Skilled nursing care | | 0% | X |
| | Durable medical equipment | | 0% | X |
| | Hospice service | | 0% | X |
| **Child eye care** | Eye exam | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | 0% | X |
| **Child Dental Diagnostic and Preventive** | Oral Exam | | Not Covered | |
| | Preventive - Cleaning | | | |
| | Preventive - X-ray | | | |
| | Sealants per Tooth | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| **Child Dental Basic Services** | Restorative Procedures | | Not Covered | |
| | Periodontal Maintenance Services | | | |
| **Child Dental Major Services** | Crowns and Casts | | Not Covered | |
| | Endodontics | | | |
| | Periodontics (other than maintenance) | | | |
| | Prosthodontics | | | |
| | Oral Surgery | | | |
| **Child Orthodontics** | Medically necessary orthodontics | | Not Covered | |

See endnotes.

**Endnotes to Covered California ~~2018~~ 2019 Patient-Centered Benefit Plan Designs**

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

**Notes:**

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network 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~~ 2019 Dental Copay Schedule.
13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder

conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

| Tier | Definition |
|---|---|
| 1 | 1) Most generic drugs and low cost preferred brands. |
| 2 | 1) Non-preferred generic drugs; |
| | 2) Preferred brand name drugs; and |
| | 3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost. |
| 3 | 1) Non-preferred brand name drugs or; |
| | 2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or; |
| | 3) Generally have a preferred and often less costly therapeutic alternative at a lower tier. |
| 4 | 1) 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.