## Covered California 2019 Patient-Centered Benefit Plan Designs<sup>1</sup>

Final Board-approved March 15, 2018

<sup>&</sup>lt;sup>1</sup> These are the Standard Benefit Plan Designs pursuant to Government Code Section 100504(c).

Date: March 15, 2018

#### Summary of Benefits and Coverage



Summary of Benefits and Coverage		* * IM			
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinum Coincurance Plan		Platinum Consv Plan	
Actuarial Value - A	·	Coinsurance Plan 91.7%		Copay Plan 88.9%	
Actuariai value - F					
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0 \$0		\$0	
	Integrated Family deductible	·		\$0 \$0 / \$0 / \$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$0 \$3,350	
	Individual Out-of-pocket maximum				
	Family Out-of-pocket maximum			\$6,700 N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A	
	. To that in plant matter accession				
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
11161	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
VISIL	•				
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15		\$15	
illness or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention					
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
,	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	<b>045</b>		<b>04 5</b>	
behavioral	visits	\$15		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
				_	
Child eye care	Eye exam  1 pair of glasses par year (or contact leases in liquid glasses)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	. 10 onarge		. 10 onaige	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	2007		See 2019 Dental	
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2019 Dental	
Services	Prosthodontics			Copay Schedule	
	Oral Surgery				
Child		500/		04.000	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance	Plan	Gold Copay Pla	ın
Actuarial Value - A	V Calculator	81.8%	riali	78.1%	Ш
	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	\$7,200		\$7,200	
	Family Out-of-pocket maximum	\$14,400		\$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	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's office or clinic	Other practitioner office visit	\$30		\$30	
visit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35		\$35	
Tests	X-rays and Diagnostic Imaging	\$55		\$55	
10010					
	Imaging (CT/PET scans, MRIs) Tier 1	20%		\$275 \$15	
		\$15			
Drugs to treat illness or	Tier 2	\$55		\$55	
condition	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$30		\$30	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	Ψ30		\$600 per day up to	
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	20%		5 days  No charge	
Mantal health	Mental/behavioral health and substance use disorder outpatient office			-	
Mental health, behavioral health, or	visits	\$30		\$30	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30		\$30	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
recovering or other special	Skilled nursing care	20%		\$300 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
		, and the second		_	
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge No charge		No charge	
		No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2019 Dental	
Services	Periodontal Maintenance Services	20%		Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2019 Dental	
Services	Prosthodontics			Copay Schedule	
	Oral Surgery				
Child	• •			4.	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan
Actuarial Value - AV Calculator		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/ \$200 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$5,000/ \$400 / \$0
	Individual Out-of-pocket maximum	\$7,550
	Family Out-of-pocket maximum	\$15,100
	HSA plan: Self-only coverage deductible	N/A
	HSA family plan: Individual deductible	N/A
Common	<u>-</u>	Deductible

	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit	\$40	
office or clinic visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Tests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharmac deductible
Drugs to treat	Tier 2	\$55	Pharmac deductibl
illness or condition	Tier 3	\$80	Pharmad
		20% up to \$250 per script	deductibl Pharmad
	Tier 4	after pharmacy deductible	deductibl
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	Х
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	Х
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	20%	
		2070	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$40	
recovering or other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	· ·	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	
Orthodontics	modically ficooscally of thoublittes	50 %	

Summary of Be	nefits and Coverage	CCSB		CCSB		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan		Silver Copay Plan		
Actuarial Value - A	AV Calculator	71.9%		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 \$2,000 / \$200 / \$0		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$200 / \$0 \$4,000 / \$400 / \$0		\$2,000 / \$200 / \$0		
	Individual Out-of-pocket maximum			\$7,550		
	Family Out-of-pocket maximum			\$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	
	Primary care visit to treat an injury, illness, or condition	\$45		\$45		
Health care provider's	Other practitioner office visit	\$45		\$45		
office or clinic	Consists visit	<b>600</b>		<b>600</b>		
visit	Specialist visit	\$80		\$80		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	\$40 \$75		\$40 \$75		
16919		\$75		\$75 \$300		
	Imaging (CT/PET scans, MRIs)	20%	Pharmacy	\$300	Pharmacy	
	Tier 1	\$15	deductible	\$15	deductible	
Drugs to treat	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible	
illness or condition	Tier 3	\$85	Pharmacy	\$85	Pharmacy	
			deductible		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	
	Surgery facility fee (e.g., ASC)	20%		20%		
Outpatient services	Physician/surgeon fees	20%		20%		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	\$350		\$350		
Need	Emergency room physician fee (waived if admitted)	No charge		No charge		
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	Х	\$250	X	
	Urgent care	\$45		\$45		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	Х	20%	X	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X	20%		
		2076	Α	2076		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$45		\$45		
health, or substance	Mantal/bahaviaral health and substance use disorder other autrations					
abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45		\$45		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$45		
Help	Outpatient Rehabilitation and Habilitation services	\$45		\$45		
recovering or	Skilled nursing care	20%	Х	20%	×	
other special health needs	Durable medical equipment	20%		20%		
	Hospice service					
	Eye exam	No charge  No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	_		No charge		
	oral Exam	No charge		No charge		
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray	No charge		No charge		
Preventive	Sealants per Tooth  Topical Fluorida Application					
	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic	Restorative Procedures	20%		See 2019 Dental Copay Schedule		
Services	Periodontal Maintenance Services			30.1044.0		
	Crowns and Casts					
Child Dental	Endodontics  Desired action (when the province area)	F00.		See 2019 Dental Copay		
Major Services	Periodontics (other than maintenance)	50%		Schedule		
	Prosthodontics					
Child	Oral Surgery					
Orthodontics	Medically necessary orthodontics	50%		\$1,000		

Date: March 15, 2018

-	enefits and Coverage	CCSE Silver	
	e amounts describe the Enrollee's out of pocket costs.	HDHP P	
Actuarial Value - A		70.5%	
	Plan design includes a deductible?  Integrated Individual deductible	Yes, integr	
	Integrated Family deductible	\$5,000 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$6,650	)
	Family Out-of-pocket maximum	\$13,30	0
	HSA plan: Self-only coverage deductible	\$2,500	
	HSA family plan: Individual deductible	See endr	lote
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	20%	X
provider's office or clinic	Other practitioner office visit	20%	Х
visit	Specialist visit	20%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	Х
Tests	X-rays and Diagnostic Imaging	20%	Х
	Imaging (CT/PET scans, MRIs)	20%	X
	Tier 1	20% up to \$250 per	Х
	Tier 2	script 20% up to \$250 per	×
Drugs to treat illness or	Her 2	script	^
condition	Tier 3	20% up to \$250 per script	X
	Tier 4	20% up to \$250 per script	X
	Surgery facility fee (e.g., ASC)	20%	Х
Outpatient services	Physician/surgeon fees	20%	Х
	Outpatient visit	20%	Х
	Emergency room facility fee (waived if admitted)	20%	Х
Need	Emergency room physician fee (waived if admitted)	0%	X
immediate attention	Medical transportation (including emergency and non-emergency)	20%	X
	Urgent care	20%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office	20%	X
behavioral health, or	visits	2076	^
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	x
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	х
Help	Outpatient Rehabilitation and Habilitation services	20%	Х
recovering or other special	Skilled nursing care	20%	X
health needs	Durable medical equipment	20%	X
	Hospice service	0%	X
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	3.	
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
Children	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	
Orthodontics			

Date: March 15, 2018

ember Cost Share amounts describe the Enrollee's out of pocket costs.  Cituarial Value - AV Calculator  Plan design includes a deductible?  Plan design includes a deductible?  Integrated Individual deductible  Integrated Family deductible  Individual deductible, NOT integrated: Medical / Pharmacy / Dental  Family deductible, NOT integrated: Medical / Pharmacy / Dental  Individual Out-of-pocket maximum  Family Out-of-pocket maximum  HSA plan: Self-only coverage deductible  N/A  Silver Plan  100%-150% FPL  94.2%  87.9%  Yes, Medical/Pharmacy  N/A  N/A  N/A  N/A  N/A  N/A  N/A  N/	PL
Plan design includes a deductible?  Integrated Individual deductible Integrated Family deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum Family Out-of-pocket maximum S1,000 Family Out-of-pocket maximum S2,000 Family Out-of-pocket maximum N/A N/A	rmacy
Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible N/A N/A N/A N/A N/A N/A N/A N/A	rmacy
Integrated Family deductible  N/A  Individual deductible, NOT integrated: Medical / Pharmacy / Dental  Family deductible, NOT integrated: Medical / Pharmacy / Dental  Individual Out-of-pocket maximum  Family Out-of-pocket maximum  S1,000  Family Out-of-pocket maximum  \$2,000  N/A  N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental         \$150 / \$0 / \$0         \$1,300 / \$100           Individual Out-of-pocket maximum         \$1,000         \$2,600           Family Out-of-pocket maximum         \$2,000         \$5,200           HSA plan: Self-only coverage deductible         N/A         N/A	
Individual Out-of-pocket maximum         \$1,000         \$2,600           Family Out-of-pocket maximum         \$2,000         \$5,200           HSA plan: Self-only coverage deductible         N/A         N/A	<b>50</b>
Family Out-of-pocket maximum \$2,000 \$5,200  HSA plan: Self-only coverage deductible N/A N/A	\$0
HSA plan: Self-only coverage deductible N/A N/A	
Common Service Type Member Cost Share Deductible Applies Member Cost Share	Deductible Applies
Primary care visit to treat an injury, illness, or condition \$5 \$15	
Health care provider's Other practitioner office visit \$5 \$15	
office or clinic	
visit Specialist visit \$8 \$25	
Preventive care/ screening/ immunization  No charge  No charge	
Laboratory Tests \$8 \$15	
Tests X-rays and Diagnostic Imaging \$8 \$30	
Imaging (CT/PET scans, MRIs) \$50 \$100	
Tier 1 \$3 \$5	
Drugs to treat Tier 2 \$10 \$20	Pharmacy deductible
condition Tier 3 \$15 \$35	Pharmacy deductible
Tier 4 10% up to \$150 per 15% up to \$150 per scrip	Pharmacy
script after pharmacy deductible	deductible
Surgery facility fee (e.g., ASC) 10% 15%  Outpatient 5	
Physician/surgeon fees 10% 15%	
Outpatient visit 10% 15%	
Emergency room facility fee (waived if admitted) \$50 \$100	
Need Emergency room physician fee (waived if admitted) No charge No charge immediate	
Medical transportation (including emergency and non-emergency) \$30 X \$75	X
Urgent care \$5 \$15	
Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  10% X 15%	X
Physician/surgeon fee 10% 15%	
Mental health, Mental/behavioral health and substance use disorder outpatient office \$5 \$15	
behavioral visits health, or	
substance Mental/behavioral health and substance use disorder other outpatient \$5	
adulate needs rems and services	
Pregnancy         Prenatal care and preconception visits         No charge         No charge	
Home health care (cost shore =====ii)	
Home health care (cost share per visit) \$3 \$15	
Help Outpatient Rehabilitation and Habilitation services \$5 \$15	
Help Outpatient Rehabilitation and Habilitation services \$5 \$15 recovering or other special Skilled nursing care 10% X 15%	X
Help Outpatient Rehabilitation and Habilitation services \$5 \$15	X
Help Outpatient Rehabilitation and Habilitation services \$5 \$15  Skilled nursing care 10% X 15%	Х
Help recovering or other special health needs  Durable medical equipment  Hospice service  Cutpatient Rehabilitation and Habilitation services  \$5 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$	X
Help recovering or other special health needs  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Stilled nursing care  No charge  No charge	X
Help recovering or other special health needs  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Outpatient Rehabilitation and Habilitation services  \$5  \$15  \$15  \$15  \$15  \$15  \$15  \$15	X
Help recovering or other special health needs  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Child eye care  Outpatient Rehabilitation and Habilitation services  \$5  \$15  \$15  X  15%  No charge  No charge  No charge  No charge  No charge  Oral Exam  Preventive - Cleaning	X
Help recovering or other special health needs  Skilled nursing care Durable medical equipment Hospice service  Child eye care  Child Dental Diagnostic  Child Dental Diagnostic  Outpatient Rehabilitation and Habilitation services  \$5 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15	X
Help recovering or other special health needs  Child eye care  Outpatient Rehabilitation and Habilitation services  Skilled nursing care Durable medical equipment Hospice service  Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Oral Exam Preventive - Cleaning  Child Dental  Outpatient Rehabilitation and Habilitation services \$5 \$15  X 15%  No charge No charge No charge No charge No charge No charge	X
Help recovering or other special health needs  Skilled nursing care 10% X 15%  Durable medical equipment 10% 15%  Hospice service No charge No charge  Child eye care  Child eye care  Child Dental Diagnostic and Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Outpatient Rehabilitation and Habilitation services \$5  No that 15%  No charge No charge No charge  No charge No charge  No charge No charge  No charge	X
Help recovering or other special health needs  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Preventive  Capital Child Preventive  Outpatient Rehabilitation and Habilitation services  \$5  \$15  \$15  \$15  \$15  \$15  \$15  \$15	X
Help recovering or other special health needs  Child Dental Diagnostic and Preventive  Child Dental Preventive  Child Dental Restorative Procedures  Child Dental Restorative Procedures  Child Dental Restorative Procedures  Child Dental Restorative Procedures  S5 \$15  \$15  \$15  \$15  \$15  \$15  \$15  \$15	X
Help recovering or other special health needs  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Preventive  Child Dental Basic Services  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  10%  X  15%  X  15%  No charge  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental Basic Services  Periodontal Maintenance Services	X
Help recovering or other special health needs  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Preventive  Child Dental Space Maintainers - Fixed  Child Dental Basic Services  Crowns and Casts  Outpatient Rehabilitation and Habilitation services  \$5  \$15  \$15  \$15  \$15  \$15  \$15  \$15	X
Help recovering or other special health needs  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Preventive  Child Dental Basic Services  Child Dental Basic Services  Child Dental Child Dental Child Dental Basic Services  Child Dental Child Dental Child Dental Child Dental Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Crowns and Casts  Endodontics  Skilled nursing care  10%  X  15%  No charge	X
Help recovering or other special health needs  Skilled nursing care  Skilled nursing care  Skilled nursing care  Skilled nursing care  Durable medical equipment  Hospice service  No charge  No charge  No charge  Peventive - Cleaning Preventive  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Basic Se	X
Help recovering or other special health needs  Skilled nursing care  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Child Preventive  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Crowns and Casts  Child Dental Major Services  Child Dental Major Services  Child Dental Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Stilled nursing care  10%  X  15%  No charge  No c	
Help recovering or other special health needs  Skilled nursing care  Skilled nursing care  Skilled nursing care  Skilled nursing care  Durable medical equipment  Hospice service  No charge  No charge  No charge  Peventive - Cleaning Preventive  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Basic Se	X

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
Actuarial Value - A	V Calculator	73.9%	-
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 / \$175 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,400 / \$350 / \$	0
	Individual Out-of-pocket maximum	\$6,300	
	Family Out-of-pocket maximum	\$12,600	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common	Service Type	Member Cost Share	Deductible
Medical Event			Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$35	
provider's office or clinic	Other practitioner office visit	\$35	
visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Tests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	Pharmac deductible
Drugs to treat	Tier 2	\$50	Pharmac deductible
illness or condition	Tier 3	\$75	Pharmac deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductible
	Surgery facility fee (e.g., ASC)	20%	deddelibi
Outpatient	Physician/surgeon fees	20%	
services			
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	Х
	Urgent care	\$35	
Heavital star	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х
Hospital stay	Physician/surgeon fee	20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
II a la	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or	Skilled nursing care	20%	Х
other special health needs	, and the second		^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	20/0	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
	Periodontics (other than maintenance) Prosthodontics	50%	
Major		50%	

Date: I	warch	15,	2018	
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Date: March	15, 2018 enefits and Coverage				
•	e amounts describe the Enrollee's out of pocket costs.	Bronze Plai	n	Bronze HDHP Plan	
Actuarial Value - A	AV Calculator	60.9%		61.6%	all
	Plan design includes a deductible?	Yes, Medical/Pha	rmacy	Yes, integra	ated
	Integrated Individual deductible	N/A		\$6,000 integ	rated
	Integrated Family deductible	N/A		\$12,000 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 /	<b>/</b> \$0	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000	) / \$0	N/A	
	Individual Out-of-pocket maximum			\$6,650	
	Family Out-of-pocket maximum	·		\$13,300	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			\$6,000 \$6,000	
	TIOA faithly plant. Individual deductible	IV/A			
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non- preventive visits	40%	Х
Health care provider's	Other practitioner office visit	\$75	After 1st three non-	40%	X
office or clinic	0	0405	preventive visits After 1st three non-	400/	
visit	Specialist visit	\$105	preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	.,
	Laboratory Tests	\$40		40%	X
Tests	X-rays and Diagnostic Imaging	100%	X	40%	X
	Imaging (CT/PET scans, MRIs)	100%	X	40%	Х
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Drugs to treat	Tier 2	100% up to \$500 per script	Pharmacy	40% up to \$500	X
illness or		after pharmacy deductible 100% up to \$500 per script	Deductible Pharmacy	per script 40% up to \$500	
condition	Tier 3	after pharmacy deductible	Deductible	per script	X
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	x
	Surgery facility fee (e.g., ASC)	100%	X	40%	Х
Outpatient	Physician/surgeon fees	100%	×	40%	x
services	Outpatient visit	100%	×	40%	X
	Emergency room facility fee (waived if admitted)	100%	×	40%	X
Need	Emergency room physician fee (waived if admitted)	No charge		0%	X
immediate attention	Medical transportation (including emergency and non-emergency)	100%	X	40%	X
attention	Urgent care	\$75	After 1st three non-	40%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		preventive visits	40 /0	
Hospital stay	delivery, mental health, and substance use)	100%	X	40%	Х
	Physician/surgeon fee	100%	X	40%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$75	After 1st three non-	40%	X
behavioral health, or	visits		preventive visits		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$75	×	40%	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
1 regnancy	Home health care (cost share per visit)	100%	X	40%	X
			^		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$75		40%	X
other special health needs	Skilled nursing care	100%	X	40%	X
nealth needs	Durable medical equipment	100%	X	40%	X
	Hospice service	No charge		0%	Х
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 charge		140 charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	2007		200/	
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
OL:11.5	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	
Orthodontics					

Date: March 15, 2018

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catas	rophic Plan
Actuarial Value - A	·		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible		0 integrated
	Integrated Family deductible	\$15,80	00 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum		\$7,900
	Family Out-of-pocket maximum  HSA plan: Self-only coverage deductible	1	15,800 N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three non-
office or clinic	·		preventive visits
visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
Tasta	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	Х
Drugs to treat	Tier 2	0%	X
illness or condition	Tier 3	0%	X
	Tier 4	0%	Х
Outpatient	Surgery facility fee (e.g., ASC)	0%	Х
services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
Need immediate	Emergency room physician fee (waived if admitted)	No charge	
attention	Medical transportation (including emergency and non-emergency)	0%	X After 1st three non-
	Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	preventive visits
Hospital stay	delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	Х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Help	Outpatient Rehabilitation and Habilitation services	0%	Х
recovering or other special	Skilled nursing care	0%	Х
health needs	Durable medical equipment	0%	X
	Hospice service	0%	Х
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed		
Basic	Restorative Procedures  Periodontal Maintenance Services	0%	X
Services	Periodontal Maintenance Services  Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	0%	X
Services	Prosthodontics		,
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	0%	X
Orthodontics			

#### 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 - A	V Calculator	91.7%	riaii	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	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15		\$15	
illness or condition	Tier 3	\$25		\$25	
	TIG 5				
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
Scrvices	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
behavioral health, or	visits				
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services				
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help .	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic	Sealants per Tooth	Not Covered		Not Covered	
and Preventive					
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	Not Covered		Not Covered	
	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Be	nefits and Coverage	Gold		Gold	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	ın
Actuarial Value - A	V Calculator	81.8%		78.1%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0 ©0		\$0 \$0	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$0 / \$0 / \$0	)	\$0 \$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0/\$0/\$	
	Individual Out-of-pocket maximum	\$7,200		\$7,200	
	Family Out-of-pocket maximum	\$14,400		\$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	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
provider's office or clinic	Other practitioner office visit	\$30		\$30	
visit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35		\$35	
Tests	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
condition	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$30		\$30	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%		\$600 per day up to	
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	20%		5 days No charge	
		2076		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$30		\$30	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$30		\$30	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$30		\$30	
recovering or other special	Skilled nursing care	20%		\$300 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child ava care	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not Covered		Not Covered	
Basic Services	Periodontal Maintenance Services	NOL COVERED		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
,	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan	
ctuarial Value - A	V Calculator	71.8%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500/ \$200 / \$0	)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ \$400 / \$0	)
	Individual Out-of-pocket maximum	\$7,550	
	Family Out-of-pocket maximum	\$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
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's office or clinic	Other practitioner office visit	\$40	
visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$35	
Tests	X-rays and Diagnostic Imaging	\$75	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1		Pharmac
		\$15	deductible Pharmac
Drugs to treat Ilness or	Tier 2	\$55	deductib
condition	Tier 3	\$80	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
0.4	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	\$250	X
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	20%	Х
	Physician/surgeon fee	20%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$40	
recovering or	Skilled nursing care	20%	X
other special health needs			^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	No charge	
DEUL D	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental	Periodontics (other than maintenance)	Not Covered	
Major Services	Prosthodontics	5510100	
Child	Oral Surgery		
Orthodontics	Medically necessary orthodontics	Not Covered	

Date: March 1		0000		000B	
•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB Silver		CCSB Silver	
		Coinsurance Plan		Copay Plan	
Actuarial Value - A		71.9%		71.6%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharmacy N/A	
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,000 / \$200 / \$0		\$2,000 / \$200 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$400 / \$0		\$4,000 / \$400 / \$	
	Individual Out-of-pocket maximum	\$7,550		\$7,550	
	Family Out-of-pocket maximum	\$15,100		\$15,100	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$45		\$45	
provider's	Other practitioner office visit	\$45		\$45	
office or clinic visit	Specialist visit	\$80		\$80	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1	\$15	Pharmacy deductible	\$15	Pharmacy deductible
Drugo to to t	Tier 2	\$55	Pharmacy	\$55	Pharmacy
Drugs to treat illness or			deductible Pharmacy		deductible Pharmacy
condition	Tier 3	\$85	deductible	\$85	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
	Surgery facility fee (e.g., ASC)	20%		20%	
Outpatient services	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$250	Х	\$250	X
	Urgent care	\$45		\$45	
Heavital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х	20%	Х
Hospital stay	Physician/surgeon fee	20%	Χ	20%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$45		\$45	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45		\$45	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$45		\$45	
recovering or other special	Skilled nursing care	20%	Х	20%	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
major dervices	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

Date: March 1	15, 2018		
Summary of Be	nefits and Coverage	CCSB Silver	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	HDHP PI	
Actuarial Value - A	V Calculator	70.5%	
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$2,500 integrated	
	Integrated Family deductible	\$5,000 integ N/A	rated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
	Individual Out-of-pocket maximum	\$6,650	
	Family Out-of-pocket maximum	\$13,300	
	HSA plan: Self-only coverage deductible	\$2,500	
	HSA family plan: Individual deductible	See endn	ote
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	20%	Х
Health care provider's	Other practitioner office visit	20%	Х
office or clinic	·		
visit	Specialist visit	20%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	X
Tests	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
	Tier 1	20% up to \$250 per script	X
Davis	Tier 2	20% up to \$250 per	X
Drugs to treat illness or	Tiel 2	script	^
condition	Tier 3	20% up to \$250 per script	X
	Tier 4	20% up to \$250 per	Х
		script	
Outpatient	Surgery facility fee (e.g., ASC)	20%	Х
services	Physician/surgeon fees	20%	Х
	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	X
Need immediate	Emergency room physician fee (waived if admitted)	0%	X
attention	Medical transportation (including emergency and non-emergency)	20%	X
	Urgent care	20%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	Х
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	20%	Х
		2070	^
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	X
health, or	Mark Mark and the state of the		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	Х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	Х
Help	Outpatient Rehabilitation and Habilitation services	20%	X
recovering or	Skilled nursing care	20%	X
other special health needs			
	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	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	NOL COVERED	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental	Periodontics (other than maintenance)	Not Covered	
	i onodonidos (otrior triair matritorianos)	1401 OUVEIEU	
Major Services	Prosthadantias		
Major Services	Prosthodontics		
Major Services Child	Prosthodontics Oral Surgery		

Summary of Benefits and Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan	
Actuarial Value - A		100%-150%		150%-200% FPL 87.9%	
Actuariar value - A	Plan design includes a deductible?			Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	•
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$1,300 / \$100 / \$6	0
	Individual Out-of-pocket maximum			\$2,600	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		J	\$5,200 N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$15	
Tests	X-rays and Diagnostic Imaging	\$8		\$30	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Drugs to treat	Tier 2	\$10		\$20	Pharmacy deductible
illness or condition	Tier 3	\$15		\$35	Pharmacy
		10% up to \$150 per		15% up to \$150 per script	deductible Pharmacy
	Tier 4	script		after pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$100	
Need immediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$30	Х	\$75	Х
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	X	15%	X
Hospital Stay	Physician/surgeon fee	10%		15%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
other special health needs	Skilled nursing care	10%	Х	15%	Х
nearth necus	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed  Restorative Procedures				
Child Dental Basic Services	Restorative Procedures  Periodontal Maintenance Services	Not Covered		Not Covered	
	Periodontal Maintenance Services  Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services	Prosthodontics  Prosthodontics	. tot Govereu		NOT COVERED	
	Oral Surgery				
Child		Not Covered		Not Covered	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Benefits and Coverage							
Member Cost Share	Member Cost Share amounts describe the Enrollee's out of pocket costs.  Silver Plan 200%-250% FPL						
Actuarial Value - A	V Calculator	73.9%					
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy				
	Integrated Individual deductible	N/A					
	Integrated Family deductible	N/A	•				
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 / \$175 / \$ \$4,400 / \$350 / \$					
	Individual Out-of-pocket maximum	\$6,300	U				
	Family Out-of-pocket maximum	\$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				
	Primary care visit to treat an injury, illness, or condition	\$35					
Health care provider's	Other practitioner office visit	\$35					
office or clinic visit	Specialist visit	\$75					
	Preventive care/ screening/ immunization	No charge					
	Laboratory Tests	\$35					
Tests	X-rays and Diagnostic Imaging	\$75					
	Imaging (CT/PET scans, MRIs)	\$300					
	Tier 1	\$15	Pharmacy deductible				
Drugs to treat	Tier 2	\$50	Pharmacy				
illness or condition	Tier 3	\$75	deductible Pharmacy				
	Tier 4	20% up to \$250 per script	deductible Pharmacy				
	Surgery facility fee (e.g., ASC)	after pharmacy deductible 20%	deductible				
Outpatient services	Physician/surgeon fees	20%					
	Outpatient visit	20%					
	Emergency room facility fee (waived if admitted)	\$350					
Need	Emergency room physician fee (waived if admitted)	No charge					
immediate	Medical transportation (including emergency and non-emergency)	\$250	X				
attention	Urgent care	\$35	^				
	Facility fee (e.g. hospital room) for inpatient stay (including labor and						
Hospital stay	delivery, mental health, and substance use)	20%	X				
	Physician/surgeon fee	20%					
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$35					
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35					
Pregnancy	Prenatal care and preconception visits	No charge					
	Home health care (cost share per visit)	\$40					
Help	Outpatient Rehabilitation and Habilitation services	\$35					
recovering or other special	Skilled nursing care	20%	X				
health needs	Durable medical equipment	20%					
	Hospice service	No charge					
	Eye exam	No charge					
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge					
	Oral Exam						
	Preventive - Cleaning						
Child Dental	Preventive - X-ray						
Diagnostic and Preventive	Sealants per Tooth	Not Covered					
	Topical Fluoride Application						
	Space Maintainers - Fixed						
Child Dental	Restorative Procedures						
Basic Services	Periodontal Maintenance Services	Not Covered					
	Crowns and Casts						
	Endodontics						
Child Dental	Periodontics (other than maintenance)	Not Covered					
Major Services	Prosthodontics						
	Oral Surgery						
Child		Not Covered					
Orthodontics	Medically necessary orthodontics	Not Covered					

Summary of	f Benefits	and Coverage
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Summary of Benefits and Coverage  Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze	
Actuarial Value - A	·	60.9%		HDHP Plan 61.6%	
/ total iai value / t	Plan design includes a deductible?	Yes, Medical/Pharmacy		Yes, integrated	
	Integrated Individual deductible	N/A	,	\$6,000 integ	
	Integrated Family deductible	N/A		\$12,000 integ	rated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$6,300 / \$500 / \$0		\$0	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000	)/\$0	N/A	
	Individual Out-of-pocket maximum	\$7,550		\$6,650	
	Family Out-of-pocket maximum			\$13,300	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			\$6,000 \$6,000	
0					
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non- preventive visits	40%	Х
Health care provider's	Other practitioner office visit	\$75	After 1st three non-	40%	X
office or clinic	· ·	·	preventive visits After 1st three non-		
visit	Specialist visit	\$105	preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge \$40		No charge 40%	X
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	100%	X	40%	X
16313	Imaging (CT/PET scans, MRIs)	100%	X	40%	X
		100% up to \$500 per script after	Pharmacy	40% up to \$500	
	Tier 1	pharmacy deductible	Deductible	per script	X
Drugs to treat	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
illness or condition	Tier 3	100% up to \$500 per script	Pharmacy	40% up to \$500	X
		after pharmacy deductible 100% up to \$500 per script	Deductible Pharmacy	per script 40% up to \$500	
	Tier 4	after pharmacy deductible	Deductible	per script	X
	Surgery facility fee (e.g., ASC)	100%	X	40%	X
Outpatient services	Physician/surgeon fees	100%	X	40%	X
	Outpatient visit	100%	X	40%	X
	Emergency room facility fee (waived if admitted)	100%	X	40%	Х
Need	Emergency room physician fee (waived if admitted)	No charge		0%	Х
immediate attention	Medical transportation (including emergency and non-emergency)	100%	X	40%	X
	Urgent care	\$75	After 1st three non- preventive visits	40%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100%	X	40%	Х
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	100%	Х	40%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-		
behavioral	visits	\$75	preventive visits	40%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient			400/	.,
abuse needs	items and services	\$75	Х	40%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	100%	Χ	40%	X
Help	Outpatient Rehabilitation and Habilitation services	\$75		40%	Х
recovering or other special	Skilled nursing care	100%	Х	40%	Х
health needs	Durable medical equipment	100%	Х	40%	X
	Hospice service	No charge		0%	X
Child	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray	No. O. and		Neces	
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	N		No. C	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
major del vices	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics	.,,	23.0.00			

Date: March 15, 2018 Summary of Benefits and Coverage					
•	amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan		
Actuarial Value - A	V Calculator				
	Plan design includes a deductible?	Yes,	integrated		
	Integrated Individual deductible	\$7,90	0 integrated		
	Integrated Family deductible	\$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 Family Out-of-pocket maximum		\$7,900 15,800		
	HSA plan: Self-only coverage deductible	Ψ	N/A		
	HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies		
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits		
Health care provider's	Other practitioner office visit	0%	After 1st three non-		
office or clinic	•		preventive visits		
visit	Specialist visit	0%	X		
	Preventive care/ screening/ immunization	No charge			
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	0%	X		
Tests	Imaging (CT/PET scans, MRIs)	0%	X		
	Tier 1	0%	Х		
Drugs to treat	Tier 2	0%	X		
illness or condition	Tier 3	0%	×		
	T4		,,		
	Tier 4	0%	Х		
Outpatient	Surgery facility fee (e.g., ASC)	0%	X		
services	Physician/surgeon fees	0%	X		
	Outpatient visit	0%	X		
	Emergency room facility fee (waived if admitted)	0%	X		
Need immediate	Emergency room physician fee (waived if admitted)	No charge			
attention	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) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X		
1100pital Stay	Physician/surgeon fee	0%	X		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	0%	After 1st three non-		
behavioral health, or	visits		preventive visits		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	X		
Pregnancy	Prenatal care and preconception visits	No charge			
	Home health care (cost share per visit)	0%	X		
Help	Outpatient Rehabilitation and Habilitation services	0%	×		
recovering or	Skilled nursing care	0%	×		
other special health needs	Durable medical equipment	0%	X		
	Hospice service	0%	X		
	Eye exam	No charge	Α		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X		
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive	Sealants per Tooth	Not Covered			
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered			
	Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered			
Major Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered			
Orthodontics	modically indeessally officeoffices	Not Covered			

#### **Endnotes to Covered California 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. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
  - 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2019 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$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 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
1101	
- 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

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

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