

Covered California ~~2018-2019~~ Patient-Centered Benefit Plan Designs¹

~~Final Proposed Board-approved
June 15, 2017²⁻³~~ March 15, 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~~

**20182019 Patient-Centered Benefit Plan Designs
10.0 EHB**

Date: ~~June 15, 2017~~ March 15, 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 medical transportation (including emergency and non-emergency)	\$150		\$150	
	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, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		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%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Restorative Procedures	20%		See 20182019 Dental Copay Schedule	
Child Dental Major Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
	Periodontics (other than maintenance)	50%		See 20182019 Dental Copay Schedule	
Child Orthodontics	Prosthodontics				
	Oral Surgery				
	Medically necessary orthodontics	50%		\$1,000	

20182019 Patient-Centered Benefit Plan Designs

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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 room Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$25 \$30		\$25 \$30	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	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	
	Substance Use disorder outpatient office visits	\$25 \$30		\$25 \$30	
	Substance Use disorder other outpatient items and services	\$25 \$30		\$25 \$30	
Pregnancy	Prenatal care and preconception visits	No charge		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%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Restorative Procedures	20%		See 20182019 Dental Copay Schedule	
Child Dental Major Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
	Periodontics (other than maintenance)	50%		See 20182019 Dental Copay Schedule	
Child Orthodontics	Prosthodontics				
	Oral Surgery				
	Medically necessary orthodontics	50%		\$1,000	

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Summary of Benefits and Coverage

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/ \$430 \$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 medical transportation (including emergency and non-emergency)	\$250	X
	Urgent care	\$35\$40	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	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	
	Substance Use disorder outpatient office visits	\$35\$40	
	Substance Use disorder other outpatient items and services	\$35\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
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		
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	20%	
	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts		
	Endodontics		
	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

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Summary of Benefits and Coverage

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

		CCSB Silver Coinsurance Plan		CCSB Silver 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 room Medical transportation (including emergency and non-emergency)	\$250	X	\$250	X
	Urgent care	\$45		\$45	
Hospital stay	Facility fee (e.g. hospital room) <u>for inpatient stay (including labor and delivery, mental health, and substance use)</u>	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	
	Substance Use disorder outpatient office visits	\$45		\$45	
	Substance Use disorder other outpatient items and services	\$45		\$45	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
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				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
	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				
	Endodontics				
	Periodontics (other than maintenance)	50%		See 2018/2019 Dental Copay Schedule	
	Prostodontics				
Child Orthodontics	Oral Surgery				
	Medically necessary orthodontics	50%		\$1,000	

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Summary of Benefits and Coverage

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

		CCSB 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		\$13,400 \$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 medical transportation (including emergency and non-emergency)	20%	X
	Urgent care	20%	X
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	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
	Substance Use disorder outpatient office visits	20%	X
	Substance Use disorder other outpatient items and services	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
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%	

20182019 Patient-Centered Benefit Plan Designs

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Date: June 15, 2017 March 15, 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 <u>\$2,600</u>	
Family Out-of-pocket maximum		\$2,000		\$4,900 <u>\$5,200</u>	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$40 <u>\$15</u>	
	Other practitioner office visit	\$5		\$40 <u>\$15</u>	
	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$8		\$15	
	X-rays and Diagnostic Imaging	\$8		\$25 <u>\$30</u>	
	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 medical transportation (including emergency and non-emergency)	\$30	X	\$75	X
	Urgent care	\$5		\$40 <u>\$15</u>	
Hospital stay	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%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$5		\$40 <u>\$15</u>	
	Mental/Behavioral health other outpatient items and services	\$5		\$40 <u>\$15</u>	
	Substance Use disorder outpatient office visits	\$5		\$40 <u>\$15</u>	
	Substance Use disorder other outpatient items and services	\$5		\$40 <u>\$15</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	\$3		\$15	
	Outpatient Rehabilitation services	\$5		\$40 <u>\$15</u>	
	Outpatient Habilitation services	\$5		\$40 <u>\$15</u>	
	Skilled nursing care	10%	X	15%	X
	Durable medical equipment	10%		15%	
Child eye care	Hospice service	No charge		No charge	
	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	
	Child Dental Diagnostic and Preventive	Oral Exam			
Preventive - Cleaning					
Preventive - X-ray					
Sealants per Tooth		No charge		No charge	
Topical Fluoride Application					
Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures	20%		20%	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts				
	Endodontics				
	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

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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 medical transportation (including emergency and non-emergency) Medical transportation (including emergency and non-emergency)	\$250	X
Hospital stay	Urgent care	\$30 \$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X
Mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	20%	-X-
	Mental/Behavioral health outpatient office visits	\$30 \$35	
	Mental/Behavioral health other outpatient items and services	\$30 \$35	
	Substance Use disorder outpatient office visits	\$30 \$35	
Pregnancy	Substance Use disorder other outpatient items and services	\$30 \$35	
	Prenatal care and preconception visits	No charge	
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%	
Child eye care	Hospice service	No charge	
	Eye exam	No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	No charge	
	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Restorative Procedures	20%	
Child Dental Major Services	Periodontal Maintenance Services		
	Crowns and Casts		
	Endodontics		
	Periodontics (other than maintenance)	50%	
Child Orthodontics	Prosthodontics		
	Oral Surgery		
	Medically necessary orthodontics	50%	

2018/2019 Patient-Centered Benefit Plan Designs

10.0 EHB

Date: ~~June 15, 2017~~ March 15, 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		\$13,400 \$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 room 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) for inpatient stay (including labor and delivery, mental health, and substance use)	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
	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
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
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				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	20%		20%	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts				
	Endodontics				
	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

2018/2019 Patient-Centered Benefit Plan Designs

10.0 EHB

Date: ~~June 15, 2017~~ **March 15, 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 room 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
	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
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
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		
Child Dental Major Services	Crowns and Casts	0%	
	Endodontics		
	Periodontics (other than maintenance)		X
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	0%	X

2018-2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017 ~~March 15, 2018~~



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan	Platinum Copoly 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 medical transportation (including emergency and non-emergency)	\$150		\$150	
	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, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		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				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	Not Covered		Not Covered	
	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				
	Endodontics				
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2018-2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017 / March 15, 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 room Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$25 \$30		\$25 \$30	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	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	
	Substance Use disorder outpatient office visits	\$25 \$30		\$25 \$30	
	Substance Use disorder other outpatient items and services	\$25 \$30		\$25 \$30	
Pregnancy	Prenatal care and preconception visits	No charge		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				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	Not Covered		Not Covered	
	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				
	Endodontics				
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child Orthodontics	Oral Surgery				
	Medically necessary orthodontics	Not Covered		Not Covered	

20182019 Patient-Centered Benefit Plan Designs

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Date: June 15, 2017March 15, 2018

Summary of Benefits and Coverage

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/ \$430 \$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) for inpatient stay (including labor and delivery, mental health, and substance use)	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	
	Substance Use disorder outpatient office visits	\$35 \$40	
	Substance Use disorder other outpatient items and services	\$35 \$40	
Pregnancy	Prenatal care and preconception visits	No charge	
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		
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	Not Covered	
	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts		
	Endodontics		
	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
Child Orthodontics	Oral Surgery		
	Medically necessary orthodontics	Not Covered	

2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017 March 15, 2018

Summary of Benefits and Coverage

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

		CCSB Silver Coinsurance Plan		CCSB Silver 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 / \$425 \$200 / \$0		\$2,000 / \$425 \$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 room Medical transportation (including emergency and non-emergency)	\$250	X	\$250	X
	Urgent care	\$45		\$45	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	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	
	Substance Use disorder outpatient office visits	\$45		\$45	
	Substance Use disorder other outpatient items and services	\$45		\$45	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
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				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	Not Covered		Not Covered	
	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				
	Endodontics				
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2018 Patient-Centered Benefit Plan Designs

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Date: June 15, 2017 March 15, 2018

Summary of Benefits and Coverage

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

Summary of Benefits and Coverage		CCSB 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
	<u>Emergency medical transportation (including emergency and non-emergency)</u>	20%	X
	Urgent care	20%	X
Hospital stay	<u>Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)</u>	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
	Substance Use disorder outpatient office visits	20%	X
	Substance Use disorder other outpatient items and services	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
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	

2018-2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017 / March 15, 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 <u>\$2,600</u>	
Family Out-of-pocket maximum		\$2,000		\$4,900 <u>\$5,200</u>	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$40 <u>\$15</u>	
	Other practitioner office visit	\$5		\$40 <u>\$15</u>	
	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$8		\$15	
	X-rays and Diagnostic Imaging	\$8		\$25 <u>\$30</u>	
	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 medical transportation (including emergency and non-emergency)	\$30	X	\$75	X
	Urgent care	\$5		\$40 <u>\$15</u>	
Hospital stay	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%	X	15%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$5		\$40 <u>\$15</u>	
	Mental/Behavioral health other outpatient items and services	\$5		\$40 <u>\$15</u>	
	Substance Use disorder outpatient office visits	\$5		\$40 <u>\$15</u>	
	Substance Use disorder other outpatient items and services	\$5		\$40 <u>\$15</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	\$3		\$15	
	Outpatient Rehabilitation services	\$5		\$40 <u>\$15</u>	
	Outpatient Habilitation services	\$5		\$40 <u>\$15</u>	
	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				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	Not Covered		Not Covered	
	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				
	Endodontics				
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

20182019 Patient-Centered Benefit Plan Designs

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Date: June 15, 2017March 15, 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 / \$430 \$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 room Medical transportation (including emergency and non-emergency)	\$250	X
	Urgent care	\$30 \$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	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	
	Substance Use disorder outpatient office visits	\$30 \$35	
	Substance Use disorder other outpatient items and services	\$30 \$35	
Pregnancy	Prenatal care and preconception visits	No charge	
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		
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	Not Covered	
	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts		
	Endodontics		
	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
Child Orthodontics	Oral Surgery		
	Medically necessary orthodontics	Not Covered	

2018-2019 Patient-Centered Benefit Plan Designs

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Date: June 15, 2017 / March 15, 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 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) for inpatient stay (including labor and delivery, mental health, and substance use)	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
	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
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
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				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	Not Covered		Not Covered	
	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				
	Endodontics				
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child Orthodontics	Oral Surgery				
	Medically necessary orthodontics	Not Covered		Not Covered	

2018/2019 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 15, 2017 / March 15, 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 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
	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
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
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	

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 ~~2018XXXX~~. 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 Dietitians 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.
- 29) For inpatient stays, if an issuer does not bill the facility fee and physician/surgeon fee separately, the issuer may combine the physician/surgeon fee with the facility fee and bill it as one charge utilizing the cost sharing requirements for the facility fee.