**California Health Benefit Exchange**
**QHP Certification Application for Plan Year 2021**
**Individual Marketplace**
**Attachment B Patient-Centered Benefit Plan Design Deviation**

**Indicate requests for deviations from the 2021 Patient-Centered Benefit Plan Designs by entering alternate cost sharing for the appropriate service type. Applicant must document rationale for each requested deviation, and rationale must include reference to regulatory compliance, administrative or operational barriers to implementing the 2021 Patient-Centered Benefit Plan Designs, and whether or not Plans & Benefits Template data entries will be impacted. For deviations that are condition- or place-specific, such as 1) waived or reduced cost shares to treat a certain disease of condition, or 2) waived or reduced cost shares for medical or pharmacy benefits that are administered in a place other than the typical site of administration, such as in the home, telehealth, etc.), add an additional sheet to this file to list the specific deviations.**

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| | | Platinum Coinsurance Plan | | Platinum Copay Plan | | Gold Coinsurance Plan | | Gold Copay Plan | | Silver Plan | | Bronze Plan | | Silver Plan 100%-150% FPL | | Silver Plan 150%-200% FPL | | Silver Plan 200%-250% FPL | | Bronze Plan | | Bronze HDHP Plan | | Catastrophic Plan | | Rationale for benefit deviation (must reference regulatory compliance, administrative or operational barriers and whether or not Plans & Benefits Template data entries will be impacted) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Enter 14-digit HIOS Plan ID: | | | | | | | | | | | | | | | | | | | | | | | | | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | 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** | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Routine Foot Care | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Other practitioner office visit** | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Acupuncture | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Diabetes Education | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Specialist visit** | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Allergy Testing | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Preventive care/ screening/ immunization | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tests | Laboratory Tests | | | | | | | | | | | | | | | | | | | | | | | | | |
| | X-rays and Diagnostic Imaging | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Imaging (CT/PET scans, MRIs) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Drugs to treat illness or condition | Tier 1 | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Tier 2 | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Tier 3 | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Tier 4 | | | | | | | | | | | | | | | | | | | | | | | | | |
| Outpatient services | **Surgery facility fee (e.g.** Abortion for Which Public Funding is Prohibited (non MSP) | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Bariatric Surgery | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Physician/surgeon fees | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Outpatient visit** | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Dialysis | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Radiation | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Chemotherapy | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Infusion Therapy | | | | | | | | | | | | | | | | | | | | | | | | | |
| Need immediate attention | Emergency room combined facility and physician fee (waived if admitted) | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Emergency medical transportation | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Urgent care | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital stay | **Facility fee (e.g. hospital room)** | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Transplant | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Reconstructive Surgery | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Treatment for TMJ | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Physician/surgeon fee | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient office visits | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Mental/Behavioral health other outpatient items and services | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Mental/Behavioral health inpatient facility fee (e.g. hospital room) | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Mental/Behavioral health inpatient physician/surgeon fee | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Substance Use disorder outpatient office visits | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Substance Use disorder other outpatient items and services | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Substance Use inpatient facility fee (e.g. hospital room) | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Substance use disorder inpatient physician/surgeon fee | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pregnancy | Prenatal care and preconception visits | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Delivery and all inpatient services – Hospital | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Delivery and all inpatient services – Professional | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Well Baby Visits | | | | | | | | | | | | | | | | | | | | | | | | | |
| Help recovering or other special health needs | Home health care | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Outpatient Rehabilitation services** | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Rehabilitative Speech Therapy | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Rehabilitative Occupational Therapy | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Rehabilitative Physical Therapy | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Outpatient Habilitation services | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Skilled nursing care | | | | | | | | | | | | | | | | | | | | | | | | | |
| | **Durable medical equipment** | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Prosthetic Device | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Hospice service | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child eye care | Eye exam | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child Dental Diagnostic and Preventive | Oral Exam | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Preventive - Cleaning | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Preventive - X-ray | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Sealants per Tooth | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Topical Fluoride Application | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Space Maintainers - Fixed | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child Dental Major Services | Root Canal- Molar | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Gingivectomy per Quad | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Extraction- Single Tooth Exposed Root or Erupted | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Extraction- Complete Bony | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Porcelain with Metal Crown | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child Orthodontics | Medically necessary orthodontics | | | | | | | | | | | | | | | | | | | | | | | | | |

See endnotes.