~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

COVERED CALIFORNIA™

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	~~89.7%~~91.2%	~~90.3%~~88.1%
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	~~$4,000~~$3,350	~~$4,000~~$3,350
Family Out-of-pocket maximum	~~$8,000~~$6,700	~~$8,000~~$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		~~$40~~$30		~~$40~~$30	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		~~$20~~$15		~~$20~~$15	
	X-rays and Diagnostic Imaging		~~$40~~$30		~~$40~~$30	
	Imaging (CT/PET scans, MRIs)		10%		~~$150~~$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%		~~$250~~$100	
	Physician/surgeon fees		10%		~~$40~~$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		$150		$150	
	Urgent care		$15		$15	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%		~~$40~~No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$15		$15	
	Mental/Behavioral health other outpatient items and services		$15		$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		10%		~~$40~~No charge	
	Substance Use disorder outpatient office visits		$15		$15	
	Substance Use disorder other outpatient items and services		$15		$15	
	Substance Use inpatient facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Substance use disorder inpatient physician fee		10%		~~$40~~No charge	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%		~~$40~~No charge	
Help recovering or other special health needs	Home health care (cost share per visit)		10%		$20	
	Outpatient Rehabilitation services		$15		$15	
	Outpatient Habilitation services		$15		$15	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

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	~~80.9%~~81.9%	~~81.2%~~78.4%
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	~~$6,750~~$6,000	~~$6,750~~$6,000
Family Out-of-pocket maximum	~~$13,500~~$12,000	~~$13,500~~$12,000
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		~~$30~~$25		~~$30~~$25	
	Other practitioner office visit		~~$30~~$25		~~$30~~$25	
	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%		~~$600~~$300	
	Physician/surgeon fees		20%		~~$55~~$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 medical transportation		$250		$250	
	Urgent care		$30		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%		~~$55~~No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		~~$30~~$25		~~$30~~$25	
	Mental/Behavioral health other outpatient items and services		~~$30~~$25		~~$30~~$25	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%		$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee		20%		~~$55~~No charge	
	Substance Use disorder outpatient office visits		~~$30~~$25		~~$30~~$25	
	Substance Use disorder other outpatient items and services		~~$30~~$25		~~$30~~$25	
	Substance Use inpatient facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Substance use disorder inpatient physician fee		20%		~~$55~~No charge	
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%		~~$55~~No charge	
Help recovering or other special health needs	Home health care (cost share per visit)		20%		$30	
	Outpatient Rehabilitation services		~~$30~~$25		~~$30~~$25	
	Outpatient Habilitation services		~~$30~~$25		~~$30~~$25	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

Summary of Benefits and Coverage	Individual
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan
Actuarial Value - AV Calculator	~~71.5%~~71.9%
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	$2,500/ ~~$250~~$100 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000/ ~~$500~~$200 / $0
Individual Out–of–pocket maximum	~~$6800~~$7,000
Family Out-of-pocket maximum	~~$13,600~~$14,000
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	
	Other practitioner office visit		$35	
	Specialist visit		$70	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		$70	
	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		$250	X
	Urgent care		$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$35	
	Mental/Behavioral health other outpatient items and services		$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$35	
	Substance Use disorder other outpatient items and services		$35	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)		$45	
	Outpatient Rehabilitation services		$35	
	Outpatient Habilitation services		$35	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

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	~~71.6%~~71.8%	~~71.3%~~71.4%
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/ ~~$250~~$100 / $0	$2,000/ ~~$250~~$100 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,000 / ~~$500~~$200 / $0	$4,000 / ~~$500~~$200 / $0
Individual Out–of–pocket maximum	$6,800	$6,800
Family Out-of-pocket maximum	$13,600	$13,600
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		$75	
	Preventive care/ screening/ immunization		No charge		No charge	
Tests	Laboratory Tests		$40		$40	
	X-rays and Diagnostic Imaging		$70		$70	
	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 medical transportation		$250	X	$250	X
	Urgent care		$45		$45	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$45		$45	
	Mental/Behavioral health other outpatient items and services		$45		$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X	20%	X
	Mental/Behavioral health inpatient physician fee		20%	X	20%	X
	Substance Use disorder outpatient office visits		$45		$45	
	Substance Use disorder other outpatient items and services		$45		$45	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X	20%	X
	Substance use disorder inpatient physician fee		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics				Not Covered	
	Periodontics (other than maintenance)				Not Covered	
	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

Summary of Benefits and Coverage	CCSB
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver HDHP Plan
Actuarial Value - AV Calculator	~~71.3%~~71.7%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$2,000 integrated
Integrated Family deductible	$4,000 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
Family Out-of-pocket maximum	$13,100
HSA plan: Self-only coverage deductible	$2,000
HSA family plan: Individual deductible	$2,600

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		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		20%	X
	Mental/Behavioral health other outpatient items and services		20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		20%	X
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

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	~~94.1%~~93.9%	~~87.5%~~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	~~$2,350~~$1,000	~~$2,350~~$2,450
Family Out-of-pocket maximum	~~$4,700~~$2,000	~~$4,700~~$4,900
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

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

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

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	~~73.7%~~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 / ~~$250~~$100 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$4,400 / ~~$500~~$200 / $0
Individual Out–of–pocket maximum	~~$5,700~~$5,850
Family Out-of-pocket maximum	~~$11,400~~$11,700
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	
	Other practitioner office visit		$30	
	Specialist visit		~~$55~~$65	
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests		$35	
	X-rays and Diagnostic Imaging		~~$65~~$70	
	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		$250	X
	Urgent care		$30	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$30	
	Mental/Behavioral health other outpatient items and services		$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	X
	Mental/Behavioral health inpatient physician fee		20%	X
	Substance Use disorder outpatient office visits		$30	
	Substance Use disorder other outpatient items and services		$30	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpatient physician fee		20%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)		$40	
	Outpatient Rehabilitation services		$30	
	Outpatient Habilitation services		$30	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

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	~~61.9%~~60.8%	~~62.0%~~61.4%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$4,800 integrated
Integrated Family deductible	N/A	$9,600 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	~~$6,800~~$7,000	$6,550
Family Out-of-pocket maximum	~~$13,600~~$14,000	$13,100
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		100%	X	40%	X
	Urgent care		$75	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		100%	X	40%	X
	Physician/surgeon fee		100%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services		$75	~~After 1st three non-preventive visits~~X	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		100%	X	40%	X
	Mental/Behavioral health inpatient physician fee		100%	X	40%	X
	Substance Use disorder outpatient office visits		$75	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services		$75	~~After 1st three non-preventive visits~~X	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)		100%	X	40%	X
	Substance use disorder inpatient physician fee		100%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No charge		No charge	
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care (cost share per visit)		100%	X	40%	X
	Outpatient Rehabilitation services		$75		40%	X
	Outpatient Habilitation services		$75		40%	X
	Skilled nursing care		100%	X	40%	X
	Durable medical equipment		100%	X	40%	X
	Hospice service		No charge		0%	X
Child eye care	Eye exam		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Services					
Child Dental Major Services	Crowns and Casts		Not Covered		Not Covered	
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

~~2017~~2018 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: ~~June 16, 2016~~January 3, 2017

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	~~$7,150~~$7,350 integrated
Integrated Family deductible	~~$14,300~~$14,700 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	~~$7,150~~$7,350
Family Out-of-pocket maximum	~~$14,300~~$14,700
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		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services		0%	~~After 1st three non-preventive visits~~X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0%	X
	Mental/Behavioral health inpatient physician fee		0%	X
	Substance Use disorder outpatient office visits		0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services		0%	~~After 1st three non-preventive visits~~X
	Substance Use inpatient facility fee (e.g. hospital room)		0%	X
	Substance use disorder inpatient physician fee		0%	X
Pregnancy	Prenatal care and preconception visits		No charge	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care (cost share per visit)		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	X
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures		Not Covered	
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts		Not Covered	
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.