Covered California 2021 Patient-Centered Benefit Plan Designs¹

Final Board-approved March 26, 2020 Actuarial Certification May 29, 2020

¹ These are the Standard Benefit Plan Designs pursuant to Government Code Section 100504(c).

2021 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: March 26, 2020 / Certified May 29, 2020



-	efits and Coverage	Individual-only F		Individual-only F	
nber Cost Share a uarial Value - AV	amounts describe the Enrollee's out of pocket costs.	Coinsurance 91.6%	r'iaN	Copay Pla 89.3%	ul
ana value - Av	Plan design includes a deductible?	91.0 <i>%</i>		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 / \$	
	Individual Out–of–pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	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	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
lealth care provider's office or	Other practitioner office visit	\$15		\$15	
linic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
)rugs to treat	Tier 2	ֆԵ \$15		\$5 \$15	
Prugs to treat					
ondition	Tier 3	\$25 10% up to \$250 per		\$25 10% up to \$250 per	
	Tier 4	script		script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
ervices	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
leed	Emergency room physician fee (waived if admitted)	No charge		No charge	
mmediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to	
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	•			
nealth, behavioral nealth, or	visits	\$15		\$15	
ubstance Ibuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
ecovering or other special	Skilled nursing care	10%		\$150 per day up to	
lealth needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	NO GIALUE		No onarge	
hild Dental	Preventive - Cleaning				
Diagnostic Ind	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental Basic	Restorative Procedures	20%		See 2021 Dental	
ervices	Periodontal Maintenance Services	2070		Copay Schedule	
	Crowns and Casts				
bild David	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2021 Dental	
Somicon				Copay Schedule	
Services	Prosthodontics				
Services	Prosthodontics Oral Surgery				

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M		

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-on Platinum Coinsurance	ı i	CCSB-onl Platinum Copay Pla	i i
uarial Value - A	V Calculator	90.5%		88.3%	
	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	\$4,500		\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible			N/A N/A	
Common	HSA family plan: Individual deductible			IN/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie
doalth care	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's office or	Other practitioner office visit	\$15		\$20	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat	Tier 2	\$25		\$20	
Iness or ondition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
leed mmediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
ttention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$20	
lospital 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	
lental	Physician/surgeon fee	10%		No charge	
ealth, ehavioral ealth, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
ecovering or other special	Skilled nursing care	10%		\$150 per day up to	
lealth needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
		-		-	
child eye are	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
hild Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
nd Preventive	Sealants per Tooth	<u> </u>		5-	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	000/		See 2021 Dental	
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental		50%		See 2021 Dental	
Child Dental Major Services	Periodontics (other than maintenance)	50%		See 2021 Dental Copay Schedule	
Major		50%			

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mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
uarial Value - AV	/ Calculator	81.9%		78.0%	
	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	D	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	D	\$0 / \$0 / \$	0
	Individual Out–of–pocket maximum	\$8,200		\$8,200	
	Family Out-of-pocket maximum	\$16,400		\$16,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
Event	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's office or	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging				
		\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$150	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
Iness or condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per		20% up to \$250 per	
		script		script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
leed mmediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
		, , , , , , , , , , , , , , , , , , ,		, i i i i i i i i i i i i i i i i i i i	
ttention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$35		\$35	
	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	
lospital stay	Physician/surgeon fee	20%		No charge	
lental		2070		No charge	
ealth, ehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
lelp ecovering or	Outpatient Rehabilitation and Habilitation services	\$35		\$35 \$300 per day up to	
ther special	Skilled nursing care	20%		5 days	
ealth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
hild over	Eye exam	No charge		No charge	
Child eye are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
		No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
nd Preventive	Sealants per Tooth	. to charge		. to only go	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	' Restorative Procedures				
Basic	Periodontal Maintenance Services	20%		See 2021 Dental Copay Schedule	
Services					
	Crowns and Casts				
Child Dental	Endodontics			0 0001 5	
	Periodontics (other than maintenance)	50%		See 2021 Dental Copay Schedule	
Major				,	
Aajor Services	Prosthodontics				
-	Prosthodontics Oral Surgery				

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		CCSB-only Gold	
uarial Value - A	·	Coinsurance Pla 78.2%	n	Copay Plan 79.4%	
uanal value - A\			201/		macy
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm N/A	асу	Yes, Medical/Phar	пасу
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common /ledical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
lealth care rovider's	Other practitioner office visit	\$25		\$35	
ffice or					
linic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
ests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	х
	Tier 1	\$15		\$15	
rugs to treat	Tier 2	\$50		\$40	
ness or ondition	Tier 3	\$80		\$70	
	Tier 4	200/ up to \$250 per ceript		20% up to \$250 per corint	
_		20% up to \$250 per script		20% up to \$250 per script	~
Dutpatient ervices	Surgery facility fee (e.g., ASC)	20%		\$300	Х
	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	х	\$250	х
leed mmediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
ttention	Medical transportation (including emergency and non-emergency)	20%	х	\$250	х
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х	\$600 per day up to 5 days	х
ospital stay	Physician/surgeon fee	20%	x	No charge	
lental ealth,	Mental/behavioral health and substance use disorder outpatient office	\$25		\$35	
ehavioral	visits	• -			
ealth, or ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
alm	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
elp ecovering or					
ther special ealth needs	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
hild Donte	Preventive - Cleaning				
hild Dental iagnostic	Preventive - X-ray	No charge		No charge	
nd reventive	Sealants per Tooth	. 10 010190			
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures	2011		See 2021 Dental Copay	
asic ervices	Periodontal Maintenance Services	20%		Schedule	
	Crowns and Casts				
	Endodontics				
hild Dental lajor	Periodontics (other than maintenance)	50%		See 2021 Dental Copay	
ervices		0070		Schedule	
	Prosthodontics Oral Surgery				

tuarial Value - A\	/ Calculator	70.5%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$	D
	Individual Out–of–pocket maximum	\$8,200	
	Family Out-of-pocket maximum	\$16,400	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common			
Medical Event	Service Type	Member Cost Share	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit	\$40	
office or clinic visit	Specialist visit	\$80	
_	Preventive care/ screening/ immunization	No charge \$40	
Tests	Laboratory Tests		
	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$85	
		\$325	Pharma
	Tier 1	\$16	deductil
Drugs to treat	Tier 2	\$60	Pharma deductil
liness or condition	Tier 3	¢00	Pharma
Jonation		\$90	deductil
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductil
Dutpatient services	Surgery facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х
Hospital stay	Physician/surgeon fee	20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$40	
abuse needs	items and services	ψτυ	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$40	
recovering or other special	Skilled nursing care	20%	х
nealth needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	_	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
Services	Crowns and Casts		
Child Dental	Endodontics	F00 /	
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		

-	nefits and Coverage	CCSB-only Silver		CCSB-only Silver	
	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plar	1	Copay Plan	
ctuarial Value - A\		71.6%		70.9%	
	Plan design includes a deductible?		асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$0	า
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$	
	Individual Out-of-pocket maximum			\$8,200	5
	Family Out-of-pocket maximum			\$16,400	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50		\$55	
Health care provider's	Other practitioner office visit	\$50		\$55	
office or					
clinic visit	Specialist visit	\$85		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$50		\$55	
Tests	X-rays and Diagnostic Imaging	\$85		\$90	
	Imaging (CT/PET scans, MRIs)	30%	х	\$300	Х
	Tier 1	\$17		\$17	
	Tier 2	\$70	Pharmacy	\$80	Pharma
Drugs to treat illness or		φ/Ο	deductible	υσφ	deductib
condition	Tier 3	\$100	Pharmacy deductible	\$110	Pharma deductib
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharma
		pharmacy deductible	deductible	pharmacy deductible	deductib
	Surgery facility fee (e.g., ASC)	30%	Х	30%	х
Outpatient services	Physician/surgeon fees	30%		30%	
	Outpatient visit	30%		30%	
	Emergency room facility fee (waived if admitted)	30%	х	30%	х
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
immediate attention	Medical transportation (including emergency and non-emergency)	30%	х	30%	х
	Urgent care	\$50		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	30%	Х	30%	Х
	Physician/surgeon fee	30%	Х	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50		\$55	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	30%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$55	
recovering or other special	Skilled nursing care	30%	х	30%	х
health needs	Durable medical equipment	30%		30%	
	Hospice service	No charge		No charge	
01.11.1	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	_		_	
	Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
Preventive					
Preventive	Topical Fluoride Application				
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental		20%		See 2021 Dental Copay	
Child Dental Basic	Space Maintainers - Fixed	20%		See 2021 Dental Copay Schedule	
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures	20%			
Child Dental Basic Services	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services	20%			
Child Dental Basic Services Child Dental	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	20%		Schedule See 2021 Dental Copay	
Preventive Child Dental Basic Services Child Dental Major Services	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)			Schedule	
Child Dental Basic Services Child Dental Major	Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics			Schedule See 2021 Dental Copay	

immary of Ber	efits and Coverage	CCSB-o	nly
mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver HDHP P	
tuarial Value - A'	✓ Calculator	71.8%	
	Plan design includes a deductible?	Yes, integ	rated
	Integrated Individual deductible	\$2,500 inte	•
	Integrated Family deductible	\$5,000 inte	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	N/A \$6,850	D
	Family Out-of-pocket maximum	\$13,70	
	HSA plan: Self-only coverage deductible	\$2,500	
	HSA family plan: Individual deductible	See endr	note
Common Medical Event	Service Type	Member Cost Share	Deductible Ap
Litoin	Primary care visit to treat an injury, illness, or condition	20%	х
lealth care provider's	Other practitioner office visit	20%	x
office or			
clinic visit	Specialist visit	20%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	x
Tests	X-rays and Diagnostic Imaging	20%	х
	Imaging (CT/PET scans, MRIs)	20%	х
	Tier 1	20% up to \$250 per script	x
Drugs to treat	Tier 2	20% up to \$250 per	x
illness or		script 20% up to \$250 per	
condition	Tier 3	script	x
	Tier 4	20% up to \$250 per script	х
Outpatient services	Surgery facility fee (e.g., ASC)	20%	x
	Physician/surgeon fees	20%	X
	Outpatient visit	20%	х
	Emergency room facility fee (waived if admitted)	20%	x
Need immediate	Emergency room physician fee (waived if admitted)	0%	x
attention	Medical transportation (including emergency and non-emergency)	20%	x
	Urgent care	20%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	x
nospital stay	Physician/surgeon fee	20%	x
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	x
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	20%	x
abuse needs Pregnancy	Prenatal care and preconception visits	No charge	
- Jognanoy	Home health care (cost share per visit)	20%	×
Halm	Outpatient Rehabilitation and Habilitation services	20%	x
Help recovering or	Skilled nursing care	20%	x
other special health needs			
	Durable medical equipment	20%	x
		0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge	
Child Dental	Preventive - Cleaning Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Sealants per room		
	Space Maintainers - Fixed		
Child Dental	Space Maintainers - Fixed Restorative Procedures		
Basic		20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics	500/	
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		1

2021 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: March 26, 2020 / Certified May 29, 2020

ember Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPL	
ctuarial Value - A	/ Calculator	94.1%		87.8%	
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pharma	асу
	Integrated Individual deductible	N/A		N/A N/A	
	Integrated Family deductible	N/A			
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	egrated: Medical / Pharmacy / Dental \$75 / \$0 / \$0 \$1,400 / \$100 / \$0)	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$2,800 / \$200 / \$0)
	Individual Out-of-pocket maximum			\$2,850	
	Family Out-of-pocket maximum		0	\$5,700	
	HSA plan: Self-only coverage deductible			N/A	
•	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
lealth care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Presidint visit	* 0		¢05	
chine visit	Specialist visit	\$8		\$25	
_	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
	Tier 2	# 40		* 05	Pharma
Drugs to treat Ilness or	Tier 2	\$10		\$25	deducti
condition	Tier 3	\$15		\$45	Pharma deducti
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharma
	Surgery facility fee (e.g., ASC)	10%		15%	
Dutpatient	Physician/surgeon fees	10%		15%	
services	Outpatient visit	10%		15%	
_	Emergency room facility fee (waived if admitted)	\$50		\$150	
laad					
leed mmediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	х	15%	х
Hospital stay	Physician/surgeon fee	10%		15%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
abuse needs					
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
lelp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%	х	15%	х
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child ave	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	i to charge		No onarge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	200/		200/	
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services		5070		5070	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

tuarial Value - A\	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL 73.3%	-
uanarvaide - AV	Plan design includes a deductible?	73.3% Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	lacy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 / \$275 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$550 / \$	0
	Individual Out–of–pocket maximum	\$6,500	
	Family Out-of-pocket maximum	\$13,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1		Pharmac
		\$16	deductibl
Drugs to treat	Tier 2	\$55	Pharmac deductibl
Ilness or condition	Tier 3	\$85	Pharma
			deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmao deductibl
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need immediate attention	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	
Mental		2078	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
health, or	Mental/behavioral health and substance use disorder other outpatient		
substance abuse needs	items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
recovering or other special	Skilled nursing care	20%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	7 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	Ŭ	
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
	c.a. cargory		

2021 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: March 26, 2020 / Certified May 29, 2020

ember Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plan	n
ctuarial Value - A\	V Calculator	64.8%		64.6%	
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integrat	ed
	Integrated Individual deductible	N/A		\$7,000 integra	ated
	Integrated Family deductible	N/A		\$14,000 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	50	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 /	/ \$0	N/A	
	Individual Out–of–pocket maximum	\$8,200		See endnot	
	Family Out-of-pocket maximum	\$16,400		See endnot	e
	HSA plan: Self-only coverage deductible	N/A		\$7,000	
Common	HSA family plan: Individual deductible	N/A		\$7,000	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	х
Health care provider's	Other practitioner office visit	\$65	After 1st three non- preventive visits	0%	x
office or clinic visit	Specialist visit	¢OE	After 1st three non-	0%	v
clinic visit	Specialist visit	\$95	preventive visits		Х
_	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	Х
Tests	X-rays and Diagnostic Imaging	40%	X	0%	Х
	Imaging (CT/PET scans, MRIs)	40%	х	0%	Х
	Tier 1	\$18	Pharmacy Deductible	0%	х
	Tior 2	40% up to \$500 per script after	Pharmacy	001	
Drugs to treat illness or	Tier 2	pharmacy deductible	Deductible	0%	X
condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
	Surgery facility fee (e.g., ASC)	40%	x	0%	х
Outpatient	Physician/surgeon fees				
services		40%	X	0%	X
	Outpatient visit	40%	Х	0%	Х
	Emergency room facility fee (waived if admitted)	40%	Х	0%	X
Need mmediate	Emergency room physician fee (waived if admitted)	No charge		0%	Х
attention	Medical transportation (including emergency and non-emergency)	40%	х	0%	х
	Urgent care	\$65	After 1st three non- preventive visits	0%	х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	X	0%	х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	40%	х	0%	x
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	x	0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	Х	0%	x
			^		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$65		0%	Х
other special	Skilled nursing care	40%	x	0%	х
health needs	Durable medical equipment	40%	x	0%	х
	Hospice service	No charge		0%	х
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	_			
	Preventive - Cleaning				
Child Dental	-				
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services	2070		2070	
	Crowns and Casts				
01.11.1	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	50%		50%	

Child Orthodontics

Medically necessary orthodontics

0%

х

-	-		
	·	Catas	rophic Plan
Actuarial Value - A			
	-		-
	-		•
		ψ17,10	N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	:	\$8,550
	Cal Share amounts describe the Enrollet's out of pocket costs. Integrated Environmental Statement of Environmental Statementer Statemental Statement of Environmental Statement of E	\$	17,100
	HSA plan: Self-only coverage deductible		N/A
-	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's office or	Other practitioner office visit	0%	After 1st three non- preventive visits
clinic visit	Specialist visit	0%	х
	Preventive care/ screening/ immunization	No charge	
Additional data base Available Plan design inductions a deductible integrated findividual deductible integrated findinitegrated findividual deductible integrated findinit	х		
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	х
Drugs to treat	Tier 2	0%	х
	Tier 3	0%	х
	Tier 4	0%	х
	Surgery facility fee (e.g., ASC)	0%	х
	Physician/surgeon fees	0%	х
	anumate describe the number of a plane basis of a plane ba	х	
	Emergency room facility fee (waived if admitted)	0%	х
	Plan design includes a deductible? Over, integrated individual deductible integrated analytical integrated individual deductible individual deductible, NOT integrated. Medical / Pharmacy / Dental Earnity deductible, NOT integrated. Medical / Pharmacy / Dental individual deductible, NOT integrated. Medical / Pharmacy / Dental indical transportation (including energency and non-emergency) indisten		
	Medical transportation (including emergency and non-emergency)	0%	х
	Urgent care	0%	After 1st three non- preventive visits
		0%	-
Hospital stay		0%	х
health,		0%	After 1st three non- preventive visits
substance		0%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	x
Heln	Outpatient Rehabilitation and Habilitation services	0%	Х
recovering or	Skilled nursing care	0%	Х
•	•	0%	×
Child			~
		-	x
Pine design incluses a deductate insegrated invited deductate is 55.50 (regrate insegrated invited deductate is 55.50 (regrate insegrated invited deductate is 55.50 (regrate insegrated invited deductate is 55.50 (regrate is 55.50 (regrate) is 55.50 (reg			
Preventive	nerror GRS have yours description of the second production production production productin production pro		
Child Dental			
Basic		0%	Х
Cervices			
		۵%	×
-		070	~
01/11	Oral Surgery		



illillarv or Deri	efits and Coverage		1		
-	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F	
tuarial Value - A\	/ Calculator	91.6%	Plan	Copay Pla 89.3%	in
	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 / \$	
	Individual Out-of-pocket maximum			\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common	Service Type	Member Cost	Deductible	Member Cost	Deduct
Medical Event	Primary care visit to treat an injury, illness, or condition	Share \$15	Applies	Share \$15	Applie
Health care provider's	Other practitioner office visit	\$15		\$15	
office or		 		ψiö	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
lests .	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Drugs to treat Ilness or condition	Tier 2	\$15		\$15	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
		script		script	
Dutpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
ervices	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
Veed mmediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
ttention	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to	
lospital stay	delivery, mental health, and substance use)			5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
ecovering or		10%		\$150 per day up to	
other special nealth needs	Skilled nursing care			5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
Ind Preventive	Sealants per Tooth	Not Covered		Not Covered	
i eventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
bervices					
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	,	CCSB-onl Platinum Copay Pla	Ĩ.
tuarial Value - A\	/ Calculator	90.5%		88.3%	
	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	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	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	Deduct Applie
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's office or	Other practitioner office visit	\$15		\$20	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	•	\$15		\$20	
Fests	Laboratory Tests X-rays and Diagnostic Imaging				
		\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
Drugs to treat Ilness or condition	Tier 1	\$10		\$5	
	Tier 2	\$25		\$20	
	Tier 3	\$40		\$30	
	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%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
Need mmediate	Emergency room physician fee (waived if admitted)				
		No charge		No charge	
attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
tention	Urgent care	\$15		\$20	
	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	
lospital stay	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
behavioral nealth, or substance	Mental/behavioral health and substance use disorder other outpatient	¢15		¢20	
abuse needs	items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
ecovering or other special	Skilled nursing care	10%		\$150 per day up to	
nealth needs	Durable medical equipment	10%		5 days 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) Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		Not Covered	
nd Preventive	Sealants per Tooth	. to onlinge			
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic	Periodontal Maintenance Services	Not Covered		Not Covered	
Services					
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				

ember Cost Share a	efits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
ctuarial Value - A\	/ Calculator	81.9%	ridii	78.0%	111
	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
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	2	\$0 / \$0 / \$	0
	Individual Out–of–pocket maximum	\$8,200		\$8,200	
	Family Out-of-pocket maximum			\$16,400	
	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	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's office or	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$150	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
illness or					
condition	Tier 3	\$80 20% up to \$250 per		\$80 20% up to \$250 per	
	Tier 4	script		script	
Outpotient	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
Need immediate attention	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	-		-	
		\$250		\$250	
	Urgent care	\$35		\$35	
Heenitel 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	
Hospital stay	Physician/surgeon fee	20%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
Help recovering or				\$300 per day up to	
other special health needs	Skilled nursing care	20%		5 days	
neutri neeus	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	_			
	Preventive - Cleaning				
Child Dental	·				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
A H H H	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		CCSB-only Gold		
		Coinsurance Pla	n	Copay Plan		
iuariai Value - A\		78.2%		79.4%		
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	Yes, Medical/Phar	macy	
	Integrated Individual deductible	N/A N/A		N/A		
	Integrated Family deductible	\$350 / \$0 / \$0		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0 \$500 / \$0 / \$0		
	Individual Out-of-pocket maximum	\$7,800		\$7,800		
	Family Out-of-pocket maximum	\$15,600		\$15,600		
	HSA plan: Self-only coverage deductible	N/A		N/A		
	HSA family plan: Individual deductible			N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care provider's office or	Other practitioner office visit	\$25		\$35		
office or		ψ£0				
linic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Larial Value - AV Car Addical Event Addical Par Addical P	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х	
	Tier 1	\$15		\$15		
rugs to treat Iness or ondition T utpatient ervices E eed nmediate ttention N	Tier 2	\$50		\$40		
	Tier 3	\$80		\$70		
_	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
Jutnationt	Surgery facility fee (e.g., ASC)	20%		\$300	Х	
	Physician/surgeon fees	20%		\$35		
	Outpatient visit	20%		20%		
leed mmediate	Emergency room facility fee (waived if admitted)	20%	х	\$250	х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Medical transportation (including emergency and non-emergency)	20%	х	\$250	х	
	Urgent care	\$25		\$35		
ttention N	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
eed frindiate ttention frindiate frindiate ttention frindiate frin	delivery, mental health, and substance use)	20%	Х	\$600 per day up to 5 days	Х	
	Physician/surgeon fee	20%	Х	No charge		
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35		
nealth, or						
buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35		
regnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
	Skilled nursing care	20%	х	\$300 per day up to 5 days	х	
	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
		-		-		
-	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
	Restorative Procedures	Not Covered		Not Covered		
	Periodontal Maintenance Services	Not Coverea		Not Covered		
	Crowns and Casts					
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics					
	Oral Surgery					

2021 Patient-Centered Benefit Plan Designs
9.5 EHB
Date: March 26, 2020 / Certified May 29, 2020

	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	
tuarial Value - A\		70.5%	
	Plan design includes a deductible?	Yes, Medical/Pharm	iacy
	Integrated Individual deductible Integrated Family deductible	N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 / \$300 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$8,000 / \$600 / \$	
	Individual Out-of-pocket maximum	\$8,200	0
	Family Out-of-pocket maximum	\$16,400	
	HSA plan: Self-only coverage deductible	\$10,400 N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care	Other practitioner office visit	\$40	
provider's office or		\$ 4 0	
clinic visit	Specialist visit	\$80	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmad
		ψIU	deductib
Drugs to treat	Tier 2	\$60	Pharma deductib
illness or condition	Tier 3	\$90	Pharma
			deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
leed mmediate ttention	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х
Hospital stay	Physician/surgeon fee	20%	
		2076	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$40	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Holp	Outpatient Rehabilitation and Habilitation services	\$40	
Help recovering or			
other special health needs	Skilled nursing care	20%	Х
illution inclus	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive			
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
-	Prosthodontics Oral Surgery		

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver		CCSB-only Silver	
	·	Coinsurance Plan	1	Copay Plan	
tuarial Value - A\		71.6%		70.9%	
	Plan design includes a deductible?		асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$0	r
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$0	
	Individual Out-of-pocket maximum			\$8,200	,
	Family Out-of-pocket maximum			\$16,400	
	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	Member Cost Share	Deductil Applie:
	Primary care visit to treat an injury, illness, or condition	\$50		\$55	
		050			
orovider's office or	Other practitioner office visit	\$50		\$55	
linic visit	Specialist visit	\$85		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$50		\$55	
ests	X-rays and Diagnostic Imaging	\$85		\$90	
ests La X-lim rugs to treat ness or ondition Tie trie utpatient ervices Su Du Du Ent eed ondiate	Imaging (CT/PET scans, MRIs)	30%	х	\$300	х
	Tier 1	\$17		\$17	
		119	Dh	μι,	D 4-
Drugs to treat	Tier 2	\$70	Pharmacy deductible	\$80	Pharma deducti
Iness or ondition	Tier 3	\$100	Pharmacy	\$110	Pharm
			deductible Pharmacy		deducti
utpatient ervices eed nmediate	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharma deducti
	Surgery facility fee (e.g., ASC)	30%	х	30%	х
Outpatient	Physician/surgeon fees	30%		30%	
Outpatient visit Emergency room facility fee (waived if admitted)	30%		30%		
leed		30%	х	30%	х
leed mmediate	Emergency room physician fee (waived if admitted)	No charge	~		
	Medical transportation (including emergency and non-emergency)	-	V	No charge	V
ttention		30%	~	30%	Х
eed E Imediate tention N	Urgent care	\$50		\$55	
lospital stav	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х	30%	Х
	Physician/surgeon fee	30%	х	30%	
lental health,	Mental/behavioral health and substance use disorder outpatient office	0.50		07-	
ehavioral	visits	\$50		\$55	
ealth, or substance	Mental/behavioral health and substance use disorder other outpatient				
buse needs	items and services	\$50		\$55	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	30%		\$45	
lelp	Outpatient Rehabilitation and Habilitation services	\$50		\$55	
ecovering or	Skilled nursing care	30%	х	30%	х
ther special ealth needs	-		^		^
	Durable medical equipment	30%		30%	
	Hospice service	No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	N=4 O		N-4 O	
nd	Sealants per Tooth	Not Covered		Not Covered	
reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
Basic	Periodontal Maintenance Services	Not Covered		Not Covered	
Services					
	Crowns and Casts				
Child Dental	Endodontics				
/lajor Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child		Not Covered		Not Covered	

	6, 2020 / Certified May 29, 2020		
-			
	·	HDHP P	lan
Actuarial Value - AN			
	•		
	Integrated Family deductible		-
	Automa and the product of product of a construct o		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	s. Silver and and a set of the se	
	r Cost Share amounts describe the Eurodes's out of pocket costs. init Value - AV Calculator Plan design includes a deductible integrated Family deductible NOT integrated family dual Ud- femily deductible, NOT integrated family dual Ud- femily deductible (e.g. ASC) Proventive and family femily femily deductible family dual Ud- femily deduction (including emergency and non-emergency) Qual entry visit Proventive and process family dual Ud- Proventive and process family discussed i admitted) Medical transportation (including emergency and non-emergency) Qual entry visit Proventive and process family discussed i admitted) Medical transportation (including emergency and non-emergency) Qual entry visit Proventive and process family entry (induity dia dual dual dual dual dual dual dual dua	\$6,850)
Common		Member Cost Share	Deductible Appli
Medical Event			Х
Health care		20%	^
provider's office or	Other practitioner office visit	20%	Х
clinic visit	Specialist visit	20%	х
	Preventive care/ screening/ immunization	No charge	
			х
Tests			х
	Imaging (CT/PET scans, MRIs)		х
	Tier 1		х
Drugs to treat	Tier 2		x
illness or	-	•	
condition	Tier 3		X
	Tier 4		х
	Surgery facility fee (e.g., ASC)	20%	х
Outpatient services	Physician/surgeon fees	20%	x
Services	Outpatient visit	20%	x
	Emergency room facility fee (waived if admitted)	20%	х
Need immediate	Emergency room physician fee (waived if admitted)	0%	x
immediate attention	Medical transportation (including emergency and non-emergency)	20%	х
	Urgent care	20%	x
		20%	х
Hospital stay			x
		20%	^
Mental health, behavioral		20%	х
health, or substance	Mental/hehavioral health and substance use disorder other outnationt		
abuse needs		20%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20%	х
Help	Outpatient Rehabilitation and Habilitation services	20%	x
recovering or	Skilled nursing care	20%	x
health needs			x
			x
Child			~
Child eye care		-	
		i to charge	
Child Dental	·		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
tuarial Value - A\	/ Calculator	94.1%		87.8%	
	Plan design includes a deductible?	Yes, Medical/F	harmacy	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$1,400 / \$100 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$2,800 / \$200 / \$0)
	Individual Out–of–pocket maximum	\$1,000)	\$2,850	
	Family Out-of-pocket maximum	\$2,000)	\$5,700	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care	Other practitioner office visit	\$5		\$15	
office or		φΟ		ψισ	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Drugs to treat Iness or condition	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
	-				Pharma
Drugs to treat	Privatility can Detection Detection Preventive care/screening/immunization No charge No charge Laboratory Tests \$8 \$20 X-rays and Diagnostic Imaging \$8 \$40 Imaging (CT/PET scans, MRIs) \$50 \$100 Tier 1 \$3 \$5 Tier 2 \$10 \$25 Tier 3 \$15 \$45 Tier 4 10% up to \$150 per script 15% up to \$150 per script 15% up to \$150 per script Surgery facility fee (e.g., ASC) 10% 15% 15% Physician/surgeon fees 10% 15% 15% Outpatient visit 10% 15% \$150 Emergency room facility fee (waived if admitted) \$50 \$150 \$150 Medical transportation (including emergency and non-emergency) \$30 \$75 \$15 Urgent care \$5 \$15 \$15 Physician/surgeon fee 10% X 15% Physician/surgeon fee \$10 \$25 \$15 Medical transportation (including emergency and non-emergency) \$30 \$75 \$15% <td>deducti</td>	deducti			
rovider's ffice or infice or or infice or or infice or or infice or or on infice or infice or on on infice or infice	Tier 3	\$15		\$45	Pharma deducti
	Tier 4	10% up to \$150 per		15% up to \$150 per script after	Pharma
	i lêr 4				deducti
	Surgery facility fee (e.g., ASC)	10%		15%	
ervices	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
eed E nmediate ttention U	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	-				
lospital stay		10%	Х	15%	Х
	Physician/surgeon fee	10%		15%	
Mental health, behavioral		\$5		\$15	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
lelp ecovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
other special	Skilled nursing care	10%	Х	15%	х
ealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
bild Dentel	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
Dervices	Prosthodontics				
	Oral Surgery				
Child		Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	200%-250% FPI	-
tuarial Value - A\	/ Calculator	73.3%	
	Plan design includes a deductible?	Yes, Medical/Pharm	lacy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 / \$275 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$550 / \$	0
	Individual Out–of–pocket maximum	\$6,500	
	Family Out-of-pocket maximum	\$13,000	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or			
clinic visit	Specialist visit	\$75	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharma
			deductil Pharma
Drugs to treat Ilness or	Tier 2	\$55	deductil
condition	Tier 3	\$85	Pharma
		20% up to \$250 per script	deductil Pharma
	Tier 4	after pharmacy deductible	deductil
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
Services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
leed nmediate ttention		-	
	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х
nospital stay	Physician/surgeon fee	20%	
Mental health.	Mental/behavioral health and substance use disorder outpatient office		
behavioral	visits	\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
		-	
	Home health care (cost share per visit)	\$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35	
recovering or other special	Skilled nursing care	20%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child ove	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	No onarge	
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Dental			
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		

2021 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: March 26, 2020 / Certified May 29, 2020

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	
tuarial Value - AV	/ Calculator	64.8%		64.6%	
	Plan design includes a deductible?	Yes, Medical/Phar	macy	Yes, integra	ated
	Integrated Individual deductible	N/A		\$7,000 integ	rated
	Integrated Family deductible	N/A		\$14,000 integ	grated
	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	\$8,200		See endno	ote
	Family Out-of-pocket maximum	\$16,400		See endno	ote
	HSA plan: Self-only coverage deductible	N/A		\$7,000	
	HSA family plan: Individual deductible	N/A		\$7,000	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	x
Health care provider's office or	Other practitioner office visit	\$65	After 1st three non- preventive visits	0%	x
clinic visit	Specialist visit	\$95	After 1st three non-	0%	x
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge	
	•	\$40		0%	x
Tasés	Laboratory Tests		, v		
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	Х	0%	X
	Tier 1	\$18	Pharmacy Deductible	0%	x
Drugs to treat liness or	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
	Surgery facility fee (e.g., ASC)	40%	x	0%	x
Dutpatient services	Physician/surgeon fees	40%	x	0%	x
el vices	Outpatient visit	40%	x	0%	x
	· Emergency room facility fee (waived if admitted)	40%	x	0%	x
leed mmediate			^		
	Emergency room physician fee (waived if admitted)	No charge		0%	X
	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
	Urgent care	\$65	After 1st three non- preventive visits	0%	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	x	0%	x
lospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	40%	х	0%	X
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	x
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	x	0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	х	0%	x
			~		
lelp ecovering or	Outpatient Rehabilitation and Habilitation services	\$65		0%	X
other special	Skilled nursing care	40%	X	0%	X
ealth needs	Durable medical equipment	40%	x	0%	x
	Hospice service	No charge		0%	x
	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	
		No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
nd Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
	Periodontal Maintenance Services				
Services	Crowns and Casts				
Services	Crowns and Casts				1
	Endodontics				
Child Dental Major		Not Covered		Not Covered	
Services Child Dental Major Services	Endodontics	Not Covered		Not Covered	
Child Dental Major	Endodontics Periodontics (other than maintenance)	Not Covered		Not Covered	

.5 EHB Date: March 2	Centered Benefit Plan Designs 6, 2020 / Certified May 29, 2020 refits and Coverage			
Vember Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan	
Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible		Yes, integrated \$8,550 integrated \$17,100 integrated		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A N/A	
Individual Out–of–pocket maximun Family Out-of-pocket maximun HSA plan: Self-only coverage deductibl		\$17,100 N/A		
Common	HSA family plan: Individual deductible Service Type	Member Cost	N/A Deductible Applies	
Medical Event		Share	After 1st three nor	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization	0% 0% 0%	preventive visits After 1st three not preventive visits X	
Tests	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	No charge 0% 0% 0%	x x x	
Drugs to treat illness or condition	Tier 1 Tier 2 Tier 3 Tier 4	0% 0% 0%	x x x x	
Outpatient services	Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit	0% 0% 0%	x x x	
Need immediate attention	Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Medical transportation (including emergency and non-emergency) Urgent care	0% No charge 0% 0%	X X After 1st three not preventive visits	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	0% 0%	x x	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services	0%	After 1st three no preventive visits	
Pregnancy	Prenatal care and preconception visits	No charge		
Help recovering or other special health needs	Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service	0% 0% 0% 0%	× × × × ×	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	х	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		
Child	Medically necessary orthodontics	Not Covered		

Endnotes to Covered California 2021 Patient-Centered Benefit Plan Designs

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

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2021 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- Member cost-share for oral anti-cancer drugs shall not exceed \$250 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 2021 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other

practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

Tier	Definition	
1	1) Most generic drugs and low cost preferred brands.	
2	1) Non-preferred generic drugs;	
	2) Preferred brand name drugs; and	
	3) Any other drugs recommended by the plan's	
	pharmaceutical and therapeutics (P&T) committee based on	
	drug safety, efficacy and cost.	
3	1) Non-preferred brand name drugs or;	
	2) Drugs that are recommended by P&T committee based	
	on drug safety, efficacy and cost or;	
	3) Generally have a preferred and often less costly	
	therapeutic alternative at a lower tier.	
4	1) Drugs that are biologics and drugs that the Food and	
	Drug Administration (FDA) or drug manufacturer requires to	
	be distributed through specialty pharmacies;	
	2) Drugs that require the enrollee to have special training or	
	clinical monitoring;	
	3) Drugs that cost the health plan (net of rebates) more than	
	six hundred dollars (\$600) net of rebates for a one-month	
	supply.	

Some drugs may be subject to zero cost-sharing under the preventive services rules.

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The Bronze and Bronze HDHP are contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2021 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.