## Covered California 20222023 Patient-Centered Benefit Plan Designs<sup>1</sup>

# Final Board-approved Proposed

Pending final AV Calculator and

Notice of Benefit and Payment Parameters for 2023 Final Rule

May 20, 2021<sup>2, 3</sup>

April 14, 2022

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

Clerical adjustment made to Silver 70 Urgent Care cost share to \$35 on March 23, 2021
 Updates made to Catastrophic Plan Out-of-Pocket maximum and deductibles to reflect federal final rule

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<sup>\*-</sup>Updates made to Catastrophic Plan Out-of-Pocket maximum and deductibles to reflect federal final rule for 2022.

Date: May 20, 2021 April 14, 2022 Summary of Benefits and Coverage



mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
	40.1.1	04.00/.04.0	v0/	00.00/.00.0	0/
tuarial Value - A\		91.6% 91.8	<u>170</u>	89.3% 89.8 No	<u>%</u>
	Plan design includes a deductible? Integrated Individual deductible	No \$0		\$0	
	Integrated Individual 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	A	Member Cost	Deductible	Member Cost	Deduc
Medical Event	Service Type	Share	Applies	Share	Appli
Hoalth care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		¢20	
Sillic Visit	Specialist visit			\$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	
	Tier 2				
Orugs to reat illness	Tier 2	\$15		\$15	
or condition	Tier 3	\$25		\$25	
	Tion A	10% up to \$250 per		10% up to \$250 per	
	Tier 4	script		script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
ici vices	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need					
mmediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
ttention					
	Urgent care	\$15		\$15	
				4050	
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	
lospitui stay	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
nealth, nehavioral	visits	\$15		\$15	
nealth, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
loln	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
lelp ecovering or				\$150 per day up to	
other special nealth needs	Skilled nursing care	10%		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				
ınd	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
Child Dents!	Space Maintainers - Fixed			Sac 2000 0000	
Child Dental Basic	Restorative Procedures	20%		See <del>2022</del> <u>2023</u> Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			Se <del>c 2022 2</del> 023	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
	Oral Gargory				

## 2022 2023 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021 April 14, 2022

Date: May 20,	<del>2021</del> <u>April 14, 2022</u>				
Summary of Bei	nefits and Coverage	CCSB-oni Platinum	•	CCSB-on	•
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance		Copay Pla	
Actuarial Value - A		<del>90.5%</del> <u>90.7</u>	<u>'%</u>	<del>88.3%</del> <u>88.8</u>	<u>8%</u>
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0	•	\$0	•
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$		\$0 / \$0 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	U	\$0 / \$0 / \$	U
	Individual Out-of-pocket maximum Family Out-of-pocket maximum			\$4,500 \$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care	Other production of the wint	0.4.5		400	
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	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
		φ10		φυ	
Drugs to	Tier 2	\$25		\$20	
treat illness or condition	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	Physician/surgeon fees	10%		\$25	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)				
Need		No charge		No charge	
immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention					
	Urgent care	\$15		\$20	
Hannital star	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	
Hospital stay	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$15		\$20	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance 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	
Mala	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
Help recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs	•			5 days	
	Durable medical equipment	10%		10%	
	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				
Obilet Desetel	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 charge		140 charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2022 2023	
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2022 2023 Dental Copay	
Services	Prosthodontics	0070		Schedule	
	Oral Surgery				
Child	• ,				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
	W0.1.1.	04.00/		70.00/.00.4	10/
tuarial Value - A		81.9%		<del>78.0%</del> <u>80.1</u>	<u> %</u>
	Plan design includes a deductible?	No \$0		No \$0	
	Integrated Individual deductible 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 / \$	
	Individual Out-of-pocket maximum	<del>\$8,200</del> <u>\$8,5</u> 5	<u>50</u>	<del>\$8,200</del> <u>\$8,5</u>	5 <u>50</u>
	Family Out-of-pocket maximum	\$16,400 <u>\$17,</u>	100	<del>\$16,400</del> <u>\$17</u>	<u>,100</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
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)	<del>20%</del> 25%		<del>\$150</del> <u>\$75</u>	
	Tier 1	\$15		\$15	
Drugs to	Tier 2	<del>\$55</del> <u>\$60</u>		<del>\$55</del> <u>\$60</u>	
treat illness or condition	Tier 3	<del>\$80</del> <u>\$85</u>		<del>\$80</del> <u>\$85</u>	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300 <u>\$150</u>	
Outpatient					
services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$35		\$35	
		<b>\$</b>		<b>\$</b>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	<del>20%</del> 30%		\$600 \$350 per day	
Hospital stay	Physician/surgeon fee	<del>20%</del> 30%		up to 5 days No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
behavioral	VISIG				
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	
II-l-	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
Help recovering or	Skilled nursing care	20% 30%		\$300 \$150 per day	
other special health needs	•			up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
50.5	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2022 2023 Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2022 2023	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

	<del>, 202</del> 1 <u>April 14, 2022</u> nefits and Coverage	CCSB-only		CCSB-only	
-	amounts describe the Enrollee's out of pocket costs.	Gold		Gold	
monipor ocor chare	California december the Empire of each position december.	Coinsurance Pla	n	Copay Plan	
Actuarial Value - A	V Calculator	<del>78.0%</del> <u>78.9%</u>		<del>79.4%</del> <u>80.5%</u>	
	Plan design includes a deductible?		acy	Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A	•	N/A	,
	Integrated Family deductible	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 Medical	Service Type	Member Cost Share	Deductible	Member Cost Share	Deductible
Event	Service Type	Member Cost Share	Applies	Welliber Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care	Other and the control of the control	405		005	
provider's office or	Other practitioner office visit	\$25		\$35	
clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
		2070		Ψ230	^
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$50		\$40	
treat illness					
or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
		2010 04 10 4200 401 001141		2010 ap 10 \$200 por comp.	
Outmatiant	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	×	\$250	х
immediate attention					
attention	Urgent care	\$25		\$35	
	Orgeni Care	φ25		φ33	
	Facility for (a.g. bospital room) for impatient about (including labor and				
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	Х
riospitai stay	Physician/surgeon fee	20%	X	No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$25		\$35	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х
health needs	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	Ů		Ů,	
	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%		See 2022 2023 Dental Copay	
Services	Periodontal Maintenance Services	20%		Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See-2022 2023 Dental Copay	
Services	, ,	00%		Schedule	
	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

10.0 EHB

Summary of	Benefits	and C	overage

lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	Plan
actuarial Value - A	V Calculator	<del>71.1%</del> <u>71.6%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	,
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 <u>\$4,750</u> / <del>\$10</del> <u>\$</u> 8	<u>85</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$7,400</del> <u>\$9,500</u> / <del>\$20</del> <u>\$1</u>	<u>70</u> / \$0
	Individual Out–of–pocket maximum	\$ <del>8,200</del> <u>\$8,750</u>	
	Family Out-of-pocket maximum	<del>\$16,400</del> <u>\$17,500</u>	
	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
Haalth aara	Primary care visit to treat an injury, illness, or condition	<del>\$35</del> <u>\$45</u>	
Health care provider's office or	Other practitioner office visit	\$35 <u>\$45</u>	
clinic visit	Specialist visit	<del>\$70</del> <u>\$85</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40 <u>\$50</u>	
Tests	X-rays and Diagnostic Imaging	\$ <del>85</del> \$95	
	Imaging (CT/PET scans, MRIs)	\$325	Pharmacy
	Tier 1	<del>\$15</del> <u>\$16</u>	deductible
Daving 4a	Tier 2	<del>\$55</del>	Pharmacy
Drugs to treat illness			deductible Pharmacy
or condition	Tier 3	<del>\$85</del> <u>\$90</u>	deductible
	Tier 4	20% up to \$250 per script	Pharmacy deductible
	Current feeith, fee (c. a. ACO)	after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$35 <u>\$45</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	200/ 200/	
Hospital stay	delivery, mental health, and substance use)	<del>20%</del> 30%	X
	Physician/surgeon fee	<del>20%</del> 30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35 <u>\$45</u>	
behavioral	visits	<u> </u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$35 <u>\$45</u>	
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits  Home health care (cost share per visit)	No charge \$45	
	, , ,		
Help recovering or	Outpatient Rehabilitation and Habilitation services	<del>\$35</del> <u>\$45</u>	
other special	Skilled nursing care	<del>20%</del> 30%	Х
health 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	J.	
	Preventive - Cleaning		
Child Dental	· ·		
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	20 /0	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
Child	Oral Surgery		
Orthodontics	Medically necessary orthodontics	50%	

	<del>-2021</del> <u>April 14, 2022</u>				
-	nefits and Coverage	CCSB-only Silver		CCSB-only Silver	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan	1	Copay Plan	
Actuarial Value - A		<del>71.4%</del> <u>71.9%</u>		<del>70.8%</del> <u>71.5%</u>	
	Plan design includes a deductible?		асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$ <del>2,250</del> \$ <u>2,500</u> / \$300	/ <b>¢</b> O	N/A \$ <del>2,250</del> \$2,500 / \$300	1 f0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ <del>4,500</del> \$5,000 / \$600		\$4,500 \\$5,000 / \$600	
	Individual Out-of-pocket maximum		/ ΦΟ	\$8,200 \$8,750	7 / <b>Φ</b> U
	Family Out-of-pocket maximum			\$16,400 \$17,500	
	HSA plan: Self-only coverage deductible			N/A	•
	HSA family plan: Individual deductible			N/A	
Common			Deductible		Deductible
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	<del>\$50</del> <u>\$55</u>		\$55	
Health care				·	
provider's office or	Other practitioner office visit	<del>\$50</del> <u>\$55</u>		\$55	
clinic visit	Specialist visit	<del>\$85</del> <u>\$90</u>		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	<del>\$50</del> <u>\$55</u>		\$55	
Tests	X-rays and Diagnostic Imaging	<del>\$85</del> <u>\$90</u>		\$90	
	Imaging (CT/PET scans, MRIs)	<del>30%</del> 35%	X	\$300	x
			•	·	
	Tier 1	<del>\$17</del> <u>\$20</u>		<del>\$17</del> <u>\$19</u>	
Drugs to	Tier 2	<del>\$70</del> <u>\$75</u>	Pharmacy deductible	<del>\$80</del> <u>\$85</u>	Pharmacy deductible
treat illness or condition	Tier 3	¢100 ¢105	Pharmacy	\$110	Pharmacy
or condition	Hel 0	<del>\$100</del> <u>\$105</u>	deductible	\$110	deductible
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	<del>30%-</del> 35%	X	<del>30%</del> 35%	X
Outpatient			^		^
services	Physician/surgeon fees	<del>30%</del> -35%		30%	
	Outpatient visit	<del>30%</del> 35%		30%	
	Emergency room facility fee (waived if admitted)	<del>30%</del> 35%	X	30%	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	<del>30%</del> 35%	X	30%	Х
attention					
	Urgent care	\$ <del>50</del> <u>\$55</u>		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	<del>30%</del> 35%	X	<del>30%</del> 40%	х
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	<del>30%</del> 35%	×	<del>30%</del> 40%	
Mental	,	<del>30/0</del> 35%	^	<del>3070</del> 4070	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$ <del>50</del> <u>\$55</u>		\$55	
behavioral health, or					
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$ <del>5</del> 0 <u>\$55</u>		\$55	
abuse needs					
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	<del>30%</del> 35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	<del>\$50</del> <u>\$55</u>		\$55	
recovering or other special	Skilled nursing care	<del>30%</del> 35%	X	<del>30%</del> 40%	X
health needs	Durable medical equipment	<del>30%</del> 35%		<del>30%</del> 40%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam			9	
	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%		See 2022 2023 Dental Copay	
Services	Periodontal Maintenance Services	2370		Schedule	
	Crowns and Casts				
Child Dowtol	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See-2022-2023 Dental Copay Schedule	
Services	Prosthodontics			Scriedule	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics	modically necessary orthodomics	JU70		φ1,000	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	•
tuarial Value - A	V Calculator	<del>71.8%</del> <u>71</u>	7%
tuariar valuo - 71	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	<del>\$2,500</del> \$2,700 i	
	Integrated Family deductible	<del>\$5,000</del> \$5,400 i	ntegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$ <del>6,850</del> <u>\$7</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$13,700 <u>\$1</u> \$2,500 <u>\$2</u>	
	HSA family plan: Individual deductible	See endr	
Common Medical Event	Service Type	Member Cost Share	Deductible Ap
	Primary care visit to treat an injury, illness, or condition	<del>20%</del> <u>25%</u>	х
Health care provider's	Other practitioner office visit	<del>20%</del> <u>25%</u>	×
office or	Considiat visit		V
clinic visit	Specialist visit	<del>20%</del> <u>25%</u>	X
	Preventive care/ screening/ immunization	No charge	.,
Toots	Laboratory Tests	<del>20%</del> <u>25%</u>	X
Tests	X-rays and Diagnostic Imaging	<del>20%</del> <u>25%</u>	X
	Imaging (CT/PET scans, MRIs)	20% 25% up to \$250	X
	Tier 1	20% 25% up to \$250 per script	×
Drugs to	Tier 2	20% 25% up to \$250	×
treat illness or condition	Tier 3	per script  20% 25% up to \$250  per script	x
	Tier 4	20% 25% up to \$250 per script	×
	Surgery facility fee (e.g., ASC)	20% 25%	X
Outpatient	Physician/surgeon fees	<del>20%</del> 25%	x
services	Outpatient visit	<del>20%</del> 25%	
	Emergency room facility fee (waived if admitted)	<del>20%</del> 25% <del>20%</del> 25%	X
	Emergency room physician fee (waived if admitted)	0%	X X
Need	Medical transportation (including emergency and non-emergency)	20% 25%	x
immediate attention	Urgent care	<del>20%</del> 25%	×
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	<del>20%</del> 25%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	<del>20%</del> 25%	×
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	<del>20%</del> 25%	х
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>20%</del> 25%	x
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	<del>20%</del> 25%	X
Help	Outpatient Rehabilitation and Habilitation services	<del>20%</del> 25%	×
recovering or other special	Skilled nursing care	<del>20%</del> 25%	×
health needs	Durable medical equipment	<del>20%</del> 25%	×
	Hospice service	0%	×
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 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	-2.7	
	Oral Surgery		
	g,		

## 2022 2023 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021 April 14, 2022

	- <mark>2021 <u>April 14, 2022</u> nefits and Coverage</mark>				
-	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		<b>Silver Plan</b> 150%-200% FPL	
		10070 100	0112	100% 200% 1112	
Actuarial Value - A		<del>94.7%</del> <u>94</u>		<del>87.8%</del> <u>87.9%</u>	
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	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	\$75 / \$0	/ \$0	\$800/ <mark>\$0 <u>\$25</u> / \$0</mark>	)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/\$0	\$1,600/ <del>\$0</del> <u>\$50</u> / \$	60
	Individual Out-of-pocket maximum	\$800 <u>\$9</u>	<u>100</u>	\$ <del>2,850</del> <u>\$3,000</u>	
	Family Out-of-pocket maximum	<del>\$1,600</del> <u>\$1</u>	<u>,800</u>	\$ <del>5,700</del> <u>\$6,000</u>	
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or				·	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
-	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	Dha
	Tier 1	\$3		\$5	Pharmacy deductible
Drugs to	Tier 2	\$10		\$25	Pharmacy deductible
treat illness or condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4	10% up to \$150 per		15% up to \$150 per script	Pharmacy
	Surgery facility fee (e.g., ASC)	script		15%	- deductible
Outpatient	Physician/surgeon fees	10%		15%	
services	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need					
immediate	Medical transportation (including emergency and non-emergency)	\$30		\$75	
attention	Urgent care	\$5		\$15	
	o.gun caro	ψ3		Ψ10	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	X	<del>15%</del> 25%	Х
Hospital stay	Physician/surgeon fee	10%		<del>15%</del> 25%	
Mental	Mental/behavioral health and substance use disorder outpatient office	¢.		¢4E	
health, behavioral	visits	\$5		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$5		\$15	
abuse needs	items and services	φ5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%	X	<del>15%</del> 25%	×
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child ava	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	90			
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic	Restorative Procedures  Periodontal Maintenance Services	20%		20%	
Services	Periodontal Maintenance Services  Crowns and Casts				
Child Dental	Endodontics  Deviadontics (other than maintanance)	F00/		F09/	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics Oral Surgery				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		50%	

## 2022 2023 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021 April 14, 2022

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan	
		200%-250% FPI	-
tuarial Value - A	V Calculator	<del>73.4%</del> <u>73.9%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 <u>\$4,750</u> / \$10 <u>\$</u>	<u>30</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$7,400</del> <u>\$9,500</u> / <del>\$20</del> <u>\$</u>	<u>60</u> / \$0
	Individual Out–of–pocket maximum	<del>\$6,300</del> <u>\$7,250</u>	
	Family Out-of-pocket maximum	<del>\$12,600</del> <u>\$14,500</u>	<u>)</u>
	HSA plan: Self-only coverage deductible	N/A	
Common	HSA family plan: Individual deductible	N/A	
Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	<del>\$35</del> <u>\$45</u>	
Health care provider's	Other practitioner office visit	<del>\$35</del> <u>\$45</u>	
office or	·	<del>400 <u>4.0</u></del>	
clinic visit	Specialist visit	<del>\$70</del> <u>\$85</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	<del>\$40</del> <u>\$50</u>	
Tests	X-rays and Diagnostic Imaging	<del>\$85</del> <u>\$90</u>	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	<del>\$15</del>	Pharma deductik
	Tier 2	ΦE.F.	Pharma
Drugs to treat illness	1101 2	\$55	deductik
or condition	Tier 3	\$85	Pharma deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductik
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)		
Nood		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	<del>\$35</del> <u>\$45</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	<del>20%</del> 30%	×
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	<del>20%</del> 30%	
Mental	, ,	2070 0070	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35 <u>\$45</u>	
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35 <u>\$45</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Holp	Outpatient Rehabilitation and Habilitation services	<del>\$35</del> <u>\$45</u>	
Help recovering or	Skilled nursing care	<del>20%</del> 30%	×
other special health 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		
Obilis B	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
_0003	Crowns and Casts		
	Endodontics		
Child Dental		500/	
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
Actuarial Value - A\		64.8% 64.5%  Yes, Medical/Pharr		<del>64.6%</del> <u>64.2</u>	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Phan	пасу	Yes, integrate \$7,000 integrates	
	Integrated Family deductible	N/A		\$14,000 integr	
	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 endnot	te
	Family Out-of-pocket maximum	\$16,400		See endnot	te
	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	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	×
Health care provider's	Other practitioner office visit	\$65	After 1st three non-	0%	×
office or	·		preventive visits After 1st three non-		
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	X
Tests	X-rays and Diagnostic Imaging	40%	×	0%	×
	Imaging (CT/PET scans, MRIs)	40%	×	0%	×
	Tier 1	\$18	Pharmacy Deductible	0%	×
	Tier 2	40% up to \$500 per script after	Pharmacy	00/	
Drugs to treat illness	Hei Z	pharmacy deductible	Deductible	0%	X
or 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
Outpatient services	Physician/surgeon fees	40%	X	0%	X
	Outpatient visit	40%	×	0%	X
	Emergency room facility fee (waived if admitted)	40%	×	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need	Medical transportation (including emergency and non-emergency)	40%	×	0%	×
immediate attention	Urgent care	\$65	After 1st three non- preventive visits	0%	x
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	x	0%	x
	Physician/surgeon fee	40%	X	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%	х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	×	0%	×
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	×
recovering or other special	Skilled nursing care	40%	X	0%	×
health needs	Durable medical equipment	40%	×	0%	×
	Hospice service	No charge		0%	×
0.11.	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	-		-	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services	2370		_3,0	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
					I
	Oral Surgery				

Summary of	Benefits	and Coverage	•

Summary of Bei	nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$8,700 <u>\$9</u>	9,100 integrated
	Integrated Family deductible	<del>\$17,400</del> <u>\$1</u>	8,200 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum		99,100
	Family Out-of-pocket maximum	<del>\$17,4</del>	00 <u>\$18,200</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A
Common	, , , , , , , , , , , , , , , , , ,		
Medical	Service Type	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-
Health care	Timary care visit to treat arranjury, miness, or condition	0 76	preventive visits
provider's	Other practitioner office visit	0%	After 1st three non- preventive visits
office or clinic visit	Specialist visit	0%	×
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	×
Tests	X-rays and Diagnostic Imaging	0%	×
	Imaging (CT/PET scans, MRIs)	0%	×
	Tier 1	0%	X
Drugs to	Tier 2	0%	X
treat illness or condition	Tier 3	0%	×
or condition	113. 0	070	^
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	×
Outpatient	Physician/surgeon fees	0%	×
services	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)		^
Need		No charge	
immediate	Medical transportation (including emergency and non-emergency)	0%	X
attention			After 1st three non-
	Urgent care	0%	preventive visits
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X
nospital stay	Physician/surgeon fee	0%	x
Mental	Mental/behavioral health and substance use disorder outpatient office	00/	After 1st three non-
health, behavioral	visits	0%	preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient	20/	
abuse needs	items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Help	Outpatient Rehabilitation and Habilitation services	0%	×
recovering or	Skilled nursing care	0%	X
other special health needs			
	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
Curo	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	110 0110190	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	00/	
Basic Services	Periodontal Maintenance Services	0%	X
	Crowns and Casts		
a	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	0%	X
Services	Prosthodontics		
	Oral Surgery		
Child		00/	V
Orthodontics	Medically necessary orthodontics	0%	Х

9.5 EHB

Date: May 20, 2021 April 14, 2022 Summary of Benefits and Coverage



mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
	va	0.4.004.04.0	.01		0.4
tuarial Value - A'		91.6% 91.8	<u> </u>	89.3% 89.8	<u>%</u>
	Plan design includes a deductible?	No \$0		No \$0	
	Integrated Individual deductible 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	O .	\$4,500	U
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common	Service Ture	Member Cost	Deductible	Member Cost	Deduc
Medical Event	Service Type	Share	Applies	Share	Appl
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests					
0313	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Orugs to	Tier 2	\$15		\$15	
reat illness	T. 0				
or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient		10%			
ervices	Physician/surgeon fees			\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
mmediate attention					
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)			5 days	
	Physician/surgeon fee	10%		No charge	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
pehavioral	visits				
nealth, or 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	
rogridino	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation and Habilitation services				
lelp ecovering or		\$15		\$15 \$150 per day up to	
other special	Skilled nursing care	10%		5 days	
nealth needs	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	Preventive - X-ray				
Diagnostic and	·	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	5370100		5370100	
	Crowns and Casts				
Shild Death	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	

Date: May 20,	<del>2021</del> <u>April 14, 2022</u>				
-	nefits and Coverage	CCSB-only Platinum		CCSB-only Platinum	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	ın
Actuarial Value - A	V Calculator	<del>90.5%</del> <u>90.7</u>	<b>'</b> %	<del>88.3%</del> <u>88.8</u>	3%
	Plan design includes a deductible?			No	<del></del>
	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	
	Family Out-of-pocket maximum			\$9,000 N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A	
Common		Member Cost	D. 1	Member Cost	D. J. Will
Medical Event	Service Type	Share	Deductible Applies	Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care	Other practitioner office visit	\$15		\$20	
provider's office or	Other practitioner office visit	\$15		φ20	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to	Tier 2	\$25		\$20	
treat illness or condition	Tier 3	\$40		\$30	
or condition	ner o				
	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	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate attention					
	Urgent care	\$15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	10%		5 days No charge	
Mental		1070		140 change	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance 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	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
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	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	140t Govered		140t Covered	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
		0.4.004		<b>70.00</b> (.00.4	
uarial Value - A		81.9%		78.0% <u>80.1</u>	<u> %</u>
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated Framily 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	<del>\$8,200</del> <u>\$8,5</u>	<u>50</u>	<del>\$8,200</del> <u>\$8,5</u>	<u>550</u>
	Family Out-of-pocket maximum	\$16,400 <u>\$17,</u>	<u>100</u>	<del>\$16,400</del> <u>\$17</u>	<u>,100</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
Josith care	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
lealth 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)	<del>20%</del> 25%		<del>\$150</del> \$75	
	Tier 1	\$15		\$15	
Orugs to	Tier 2	<del>\$55</del> <u>\$60</u>		<del>\$55</del> <u>\$60</u>	
reat illness	Tier 3	<del>\$80</del>		<del>\$80</del> <u>\$85</u>	
or condition		20% up to \$250 per		20% up to \$250 per	
	Tier 4	script		script	
	Surgery facility fee (e.g., ASC)	20%		\$300 <u>\$150</u>	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
ttention	Urgent care	\$35		\$35	
lospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	<del>20%</del> 30%		\$600 \$350 per day up to 5 days	
lental	Physician/surgeon fee	<del>20%</del> 30%		No charge	
nealth, pehavioral nealth, or	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
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	
recovering or other special	Skilled nursing care	<del>20%</del> 30%		\$300 \$150 per day up to 5 days	
nealth needs	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	Preventive - X-ray				
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				

Date: May 20, 2021 April 14, 2022 Summary of Benefits and Coverage CCSB-only CCSB-only						
-	amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		Gold		
Welliber Cost Gridie	amounts describe the Emories 5 out of pooket desta.	Coinsurance Pla	n	Copay Plan		
Actuarial Value - A	V Calculator	<del>78.0%</del> <u>78.9%</u>		<del>79.4%</del> <u>80.5%</u>		
	Plan design includes a deductible?		acy	Yes, Medical/Pharr	nacy	
	Integrated Individual deductible	N/A	•	N/A	·	
	Integrated Family deductible	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 Medical	Service Type	Member Cost Share	Deductible	Member Cost Share	Deductible	
Event		Monibor Goot Gride	Applies	member out chare	Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care provider's	Other practitioner office visit	\$25		\$35		
office or		·				
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х	
	Tier 1	\$15		\$15		
Drugs to	Tier 2	\$50		\$40		
treat illness or condition	Tier 3	\$80		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300	X	
Outpatient services	Physician/surgeon fees	20%		\$35		
Services	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	×	\$250	Х	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Medical transportation (including emergency and non-emergency)	20%	×	\$250	x	
immediate	medical transportation (including emergency and non-emergency)	2070	^	φ230	^	
attention						
	Urgent care	\$25		\$35		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	X	
rioopital otay	Physician/surgeon fee	20%	X	No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office					
health, behavioral	visits	\$25		\$35		
health, or	Mental/behavioral health and substance use disorder other outpatient					
substance abuse needs	items and services	\$25		\$35		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
Holm	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
Help recovering or			V		v	
other special health needs	Skilled nursing care	20%	×	\$300 per day up to 5 days	X	
	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					
A	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray	N-4 Courses		Not Occurred		
and Preventive	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
OUI VICES	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		

Summary of	Renefits	and (	Coverage

lember Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	r Plan
actuarial Value - A	V Calculator	<del>71.1%</del> <u>71.6%</u>	
ictuariai value - A	Plan design includes a deductible?	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	acy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 <u>\$4,750</u> / <del>\$10</del> <u>\$</u> 8	<u>35</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$7,400</del> <u>\$9,500</u> / <del>\$20</del> <u>\$1</u>	<u>70</u> / \$0
	Individual Out–of–pocket maximum	<del>\$8,200</del> <u>\$8,750</u>	
	Family Out-of-pocket maximum	<del>\$16,400</del> <u>\$17,500</u>	
	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	Primary care visit to treat an injury, illness, or condition	<del>\$35</del> <u>\$45</u>	
provider's office or	Other practitioner office visit	\$35 <u>\$45</u>	
clinic visit	Specialist visit	<del>\$70</del> <u>\$85</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	<del>\$40</del> \$50	
Tests	X-rays and Diagnostic Imaging	<del>\$85</del> \$95	
	Imaging (CT/PET scans, MRIs)	\$325	
			Pharmacy
	Tier 1	<del>\$15</del> <u>\$16</u>	deductible
Drugs to	Tier 2	<del>\$55</del> <u>\$60</u>	Pharmacy deductible
treat illness or condition	Tier 3	<del>\$85</del>	Pharmacy
or containen			deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need			
immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$ <del>35</del> <u>\$45</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	<del>20%</del> 30%	Х
	Physician/surgeon fee	<del>20%</del> 30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	<del>\$35</del>	
behavioral	visits	<del>φου</del> <u>φ+υ</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	<del>\$35</del> <u>\$45</u>	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge	
Tognancy	Home health care (cost share per visit)	\$45	
	, , ,		
Help recovering or	Outpatient Rehabilitation and Habilitation services	<del>\$35</del> <u>\$45</u>	
other special	Skilled nursing care	<del>20%</del> 30%	X
health 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 Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
COI VICES	Crowns and Casts		
	Endodontics		
Child Dental		Not Cover-	
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
Child	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

9.5 EHB

	nefits and Coverage	CCSB-only		CCSB-only	
-	amounts describe the Enrollee's out of pocket costs.	Silver		Silver	
		Coinsurance Plan		Copay Plan	
Actuarial Value - A	V Calculator	<del>71.4%</del> <u>71.9%</u>		<del>70.8%</del> <u>71.5%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	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	\$ <del>2,250</del> <u>\$2,500</u> / \$300	/ \$0	<del>\$2,250</del> <u>\$2,500</u> / \$300 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$4,500</del> <u>\$5,000</u> / \$600	/ \$0	<del>\$4,500</del> <u>\$5,000</u> / \$600 / \$0	
	Individual Out–of–pocket maximum	<del>\$8,200</del> <u>\$8,600</u>		<del>\$8,200</del> <u>\$8,750</u>	
	Family Out-of-pocket maximum			\$16,400 <u>\$17,500</u>	<u>)</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common	TIO/ Talling plan. Individual deduction	TV/A			
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	050.055		055	
Health care	Filmary care visit to treat an injury, limess, or condition	<del>\$50</del> <u>\$55</u>		\$55	
provider's	Other practitioner office visit	\$ <del>50</del> <u>\$55</u>		\$55	
office or clinic visit	Specialist visit	<del>\$85</del> \$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$50 \$55		\$55	
Tests	X-rays and Diagnostic Imaging	\$ <del>85</del> \$ <u>90</u>		\$90	
	Imaging (CT/PET scans, MRIs)	3 <del>0%</del> 35%	×	\$300	×
			, ,	·	, ,
	Tier 1	<del>\$17</del> <u>\$20</u>	_	<del>\$17</del> <u>\$19</u>	
Drugs to	Tier 2	<del>\$70</del> <u>\$75</u>	Pharmacy deductible	<del>\$80</del> <u>\$85</u>	Pharmacy deductible
treat illness or condition	Tier 3	\$ <del>100</del> \$10 <u>5</u>	Pharmacy	\$110	Pharmacy
5. 30.10.1011			deductible		deductible
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	<del>30%</del> 35%	X	<del>30%</del> 35%	X
Outpatient	Physician/surgeon fees	<del>30%</del> 35%		30%	
services	Outpatient visit	<del>30%</del> 35%		30%	
	Emergency room facility fee (waived if admitted)	<del>30%</del> 35%	×	30%	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	30% 35%	×	30%	X
immediate	medical transportation (including emergency and not remergency)	3070 3070	^	30 %	^
attention	Hereat care	050.055		055	
	Urgent care	<del>\$50</del> <u>\$55</u>		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	<del>30%</del> 35%	X	<del>30%</del> 40%	X
	Physician/surgeon fee	<del>30%</del> 35%	X	<del>30%</del> 40%	
Mental	Mental/behavioral health and substance use disorder outpatient office	<del>\$50</del> \$55		\$55	
health, behavioral	visits	<del>დას</del> დაა		φυσ	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$50 \$55		\$55	
abuse needs	items and services	φ55 ψ55		450	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	<del>30%</del> 35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	<del>\$50</del> <u>\$55</u>		\$55	
recovering or other special	Skilled nursing care	<del>30%</del> 35%	X	<del>30%</del> 40%	X
health needs	Durable medical equipment	<del>30%</del> 35%		<del>30%</del> 40%	
	Hospice service	No charge		No charge	
Object and	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	110 Shargo		110 Sharge	
	Preventive - Cleaning				
Child Dental	•				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
01:11.7	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	
Get vices	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB Date: May 20.	<del>-2021</del> April 14, 2022			
•	nefits and Coverage	CCSB-o	nly	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver HDHP P		
Actuarial Value - A		<del>71.8%</del> <u>71</u>	<u>.1%</u>	
	Plan design includes a deductible?	Yes, integ		
	Integrated Individual deductible Integrated Family deductible	\$2,500 <u>\$2,700</u> i \$5,000 <u>\$5,400</u> i	-	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A		
	Individual Out-of-pocket maximum	<del>\$6,850</del> <u>\$7</u>	.200	
	Family Out-of-pocket maximum	\$13,700 <u>\$1</u>	<u>4,400</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	<del>\$2,500</del> <u>\$2</u> See endr		
Common Medical	Service Type	Member Cost Share		
Event	Primary care visit to treat an injury, illness, or condition	<del>20%</del> <u>25%</u>	×	
Health care provider's	Other practitioner office visit	<del>20%</del> <u>25%</u>	x	
office or clinic visit	Specialist visit	<del>20%</del> <u>25%</u>	x	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	<del>20%</del> <u>25%</u>	X	
Tests	X-rays and Diagnostic Imaging	<del>20%</del> <u>25%</u>	×	
	Imaging (CT/PET scans, MRIs)	<del>20</del> % <u>25%</u>	x	
	Tier 1	20% 25% up to \$250	×	
		per script 20% 25% up to \$250		
Drugs to treat illness	Tier 2	per script	X	
or condition	Tier 3	20% 25% up to \$250 per script	X	
	Tier 4	20% 25% up to \$250	×	
		per script		
Outpatient	Surgery facility fee (e.g., ASC)	<del>20%</del> 25%	X	
services	Physician/surgeon fees	20% 25%	X	
	Outpatient visit	<del>20%</del> 25%	X	
	Emergency room facility fee (waived if admitted)	<del>20%</del> 25%	X	
Need	Emergency room physician fee (waived if admitted)	0% <del>20%</del> 25%	X	
immediate	Medical transportation (including emergency and non-emergency)	<del>20%</del> 25%	X	
attention	Unantana	<del>20%</del> 25%		
	Urgent care	<del>20%</del> 25%	X	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	<del>20%</del> 25%		
Hospital stay	delivery, mental health, and substance use)		X	
Montel	Physician/surgeon fee	<del>20%</del> 25%	X	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	<del>20%</del> 25%	X	
behavioral health, or	Manda Washa silang bangkan dan kabanan ang dipandan aktan ang sakating			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>20%</del> 25%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	<del>20%</del> 25%	x	
Help	Outpatient Rehabilitation and Habilitation services	<del>20%</del> 25%	×	
recovering or other special	Skilled nursing care	<del>20%</del> 25%	×	
health needs	Durable medical equipment	<del>20%</del> 25%	x	
	Hospice service	0%	X	
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 Diagnostic	Preventive - X-ray	N-4 O		
and Preventive	Sealants per Tooth	Not Covered		
Ovonuve	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	Not Covered		
001 ¥1069	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics	Not Covered		

Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention	Calculator  Plan design includes a deductible?  Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible  Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees  Outpatient visit	N/A N/A N/A N/A \$75 / \$0 \$150 / \$0 \$150 / \$0 \$800 \$9 \$1,600 \$1 N/A N/A Member Cost Share \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	Pharmacy / \$0 / \$0 <u>00</u>	87.8% 87.9% Yes, Medical/Pharm N/A N/A \$800/ \$0 \$25 / \$0 \$1,600/ \$0 \$50 / \$ \$2,850 \$3.000 N/A N/A N/A  Member Cost Share  \$15 \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	)
Common Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention	Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible  Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	Yes, Medical/F	Pharmacy  / \$0  / \$0  00  800  Deductible	Yes, Medical/Pharm N/A N/A \$800/ \$0 \$25 / \$0 \$1,600/ \$0 \$50 / \$ \$2,850 \$3,000 \$5,700 \$6,000 N/A N/A  Member Cost Share  \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	Deductible Applies  Pharmacy deductible Pharmacy deductible
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Integrated Individual deductible Integrated Family deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible  Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	N/A N/A N/A N/A \$75 / \$0 \$150 / \$0 \$150 / \$0 \$800 \$9 \$1,600 \$1 N/A N/A Member Cost Share \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	/ \$0 / \$0 00 .800	N/A N/A N/A \$800/ \$0 \$25 / \$0 \$1,600/ \$0 \$50 / \$ \$2,850 \$3,000 \$5,700 \$6,000 N/A N/A  Member Cost Share  \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	Deductible Applies  Pharmacy deductible Pharmacy deductible Pharmacy
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	N/A \$75 / \$0 \$150 / \$0 \$150 / \$0 \$8800 \$9 \$1,600 \$1 N/A N/A  Member Cost Share \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	/ \$0 00 ,800	N/A \$800/ \$0 \$25 / \$0 \$1,600/ \$0 \$50 / \$ \$2,850 \$3,000 \$5,700 \$6,000  N/A N/A  Member Cost Share  \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	Deductible Applies  Pharmacy deductible Pharmacy deductible
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$150 / \$0  \$800 \$9  \$1,600 \$1  N/A  Member Cost Share  \$5  \$8  No charge  \$8  \$8  \$50  \$3  \$10  \$15  10% up to \$150 per script	/ \$0 00 ,800	\$1,600/ \$0 \$50 / \$ \$2,850 \$3,000 \$5,700 \$6,000  N/A N/A  Member Cost Share  \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	Deductible Applies  Pharmacy  deductible Pharmacy  deductible
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$800 \$9 \$1,600 \$1 N/A N/A Member Cost Share  \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	00 ,800 Deductible	\$2,860 \$3,000 \$5,700 \$6,000  N/A N/A  Member Cost Share  \$15 \$15 \$25  No charge \$20 \$40 \$100 \$5 \$25	Deductible Applies  Pharmacy  deductible Pharmacy
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$1,600 \$1  N/A  N/A  Member Cost Share  \$5  \$5  \$8  No charge \$8  \$8  \$50  \$3  \$10  \$15  10% up to \$150 per script	,800  Deductible	\$5,700 \$6,000  N/A  N/A  Member Cost Share  \$15  \$15  \$25  No charge  \$20  \$40  \$100  \$5  \$25	Pharmacy deductible Pharmacy deductible
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	N/A N/A N/A Member Cost Share  \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	Deductible	N/A N/A N/A  Member Cost Share  \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	Pharmacy deductible Pharmacy deductible
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit  Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging  Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	N/A  Member Cost Share  \$5  \$5  \$8  No charge  \$8  \$8  \$50  \$3  \$10  \$15  10% up to \$150 per script		N/A  Member Cost Share  \$15  \$15  \$25  No charge  \$20  \$40  \$100  \$5  \$25	Pharmacy deductible Pharmacy deductible
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention	Service Type  Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit  Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging  Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	### Member Cost Share  \$5  \$5  \$8  No charge  \$8  \$8  \$50  \$3  \$10  \$15  10% up to \$150 per script		\$15 \$15 \$25 No charge \$20 \$40 \$100 \$5	Pharmacy deductible Pharmacy deductible
Medical Event  Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Primary care visit to treat an injury, illness, or condition  Other practitioner office visit  Specialist visit  Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging  Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	\$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15  10% up to \$150 per script		\$15 \$15 \$25 No charge \$20 \$40 \$100 \$5	Pharmacy deductible Pharmacy deductible
Health care provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Other practitioner office visit  Specialist visit  Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging  Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	\$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15		\$15 \$25 No charge \$20 \$40 \$100 \$5	deductible Pharmacy deductible
provider's office or clinic visit  Tests  Drugs to treat illness or condition  Outpatient services  Need immediate attention  Hospital stay	Specialist visit  Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging  Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	\$8  No charge  \$8  \$8  \$50  \$3  \$10  \$15  10% up to \$150 per script		\$25  No charge \$20 \$40 \$100 \$5	deductible Pharmacy deductible
Outpatient services  Need immediate attention  Hospital stay	Specialist visit  Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging  Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	\$8  No charge  \$8  \$8  \$50  \$3  \$10  \$15  10% up to \$150 per script		\$25  No charge \$20 \$40 \$100 \$5	deductible Pharmacy deductible
Drugs to treat illness or condition  Outpatient services  Need immediate attention	Preventive care/ screening/ immunization  Laboratory Tests  X-rays and Diagnostic Imaging  Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	\$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		No charge \$20 \$40 \$100 \$5 \$25	deductible Pharmacy
Drugs to treat illness or condition  Outpatient services  Need immediate attention	Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		\$20 \$40 \$100 \$5 \$25	deductible Pharmacy
Drugs to treat illness or condition  Outpatient services  Need immediate attention	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		\$40 \$100 \$5 \$25	deductible Pharmacy deductible
Drugs to treat illness or condition  Outpatient services  Need mmediate attention  Hospital stay	Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	\$50 \$3 \$10 \$15 10% up to \$150 per script		\$100 \$5 \$25	deductible Pharmacy deductible
Drugs to treat illness or condition  Outpatient services  Need immediate attention	Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$3 \$10 \$15 10% up to \$150 per script		\$5 \$25	deductible Pharmacy deductible
Drugs to treat illness or condition  Outpatient services  Need mmediate attention  Hospital stay	Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$10 \$15 10% up to \$150 per script		\$25	deductible Pharmacy deductible
Outpatient services  Need mmediate attention	Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees	\$15 10% up to \$150 per script			deductible
Outpatient services  Need mmediate attention	Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	10% up to \$150 per script		\$45	Phormoc
Outpatient services  Need immediate attention	Surgery facility fee (e.g., ASC) Physician/surgeon fees	script			deductible
Outpatient services  Need immediate attention  Hospital stay	Physician/surgeon fees	·		15% up to \$150 per script	Pharmacy deductible
Need immediate attention	•	10%		15%	
Need immediate attention	Outpatient visit	10%		15%	
Need immediate attention Hospital stay		10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$50		\$150	
Need immediate attention	Emergency room physician fee (waived if admitted)				
immediate attention Hospital stay		No charge		No charge	
Hospital stay	Medical transportation (including emergency and non-emergency)	\$30		\$75	
Hospital stay	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	X	<del>15%</del> 25%	X
	Physician/surgeon fee	10%		<del>15%</del> 25%	
	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	<del>15%</del> 25%	×
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
	Eye exam			_	
criiid eye		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	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
	Periodontal Maintenance Services	0070100			
	Crowns and Casts				
Child Dontal					
•	Endodontics	Not Covered		Not Covered	
Services	Endodontics Periodontics (other than maintenance)				
Child	Periodontics (other than maintenance)				

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan	
	anicanic accessive the Emerica states period costati	200%-250% FPI	-
tuarial Value - A	V Calculator	<del>73.4%</del> <u>73.9%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	пасу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 <u>\$4,750</u> / \$10 <u>\$</u>	<u>30</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$7,400</del> <u>\$9,500</u> / <del>\$20</del> <u>\$</u> 1	<u>60</u> / \$0
	Individual Out-of-pocket maximum	<del>\$6,300</del> <u>\$7,250</u>	
	Family Out-of-pocket maximum	<del>\$12,600</del> <u>\$14,500</u>	<u>)</u>
	HSA plan: Self-only coverage deductible	N/A	
0	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	<del>\$35</del> <u>\$45</u>	
Health care provider's	Other practitioner office visit	<del>\$35</del> <u>\$45</u>	
office or		_	
clinic visit	Specialist visit	<del>\$70</del>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	<del>\$40</del> <u>\$50</u>	
Tests	X-rays and Diagnostic Imaging	<del>\$85</del> <u>\$90</u>	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	<del>\$15</del>	Pharma deductik
	Tier 2	\$55	Pharma
Orugs to reat illness			deductik Pharma
or condition	Tier 3	\$85	deductik
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
mmediate	meanant and personal (meanang and gener) and near and genery,	<b>\$200</b>	
attention	Urgent care	<del>\$35</del> \$45	
	-		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	<del>20%</del> 30%	Х
nospital stay	Physician/surgeon fee	<del>20%</del> 30%	
Viental	Mental/behavioral health and substance use disorder outpatient office	<b>005.045</b>	
nealth, pehavioral	visits	\$35 <u>\$45</u>	
health, or	Mental/behavioral health and substance use disorder other outpatient		
substance abuse needs	items and services	\$35 <u>\$45</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	<del>\$35</del> <u>\$45</u>	
ecovering or	Skilled nursing care	<del>20%</del> 30%	×
other special nealth needs			_ ^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	N-4 O	
and Preventive	Sealants per Tooth	Not Covered	
reventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
23111303	Crowns and Casts		
	Endodontics		
Child Dental		Not Covered	
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

9.5 EHB

	nefits and Coverage				
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan	Bronze HDHP Plan		
A - t i - 1 \ / - l A	W Colombia	C4 00/ C5 40/		C4 C9/ C4 D	0/
Actuarial Value - A	V Calculator  Plan design includes a deductible?	64.8% 65.4%  Yes, Medical/Pharr	macy	<del>64.6%</del> <u>64.2</u> Yes, integral	
	Integrated Individual deductible	N/A	пасу	\$7,000 integral	
	Integrated Family deductible	N/A		\$14,000 integr	ated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	\$O	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	te
	Family Out-of-pocket maximum	\$16,400		See endnot	te
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		\$7,000 \$7,000	
Common	1 O Talling plant mariatal could be	rioa ranniy pian. individual deductible		ψ.,σσσ	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	×
Health care provider's	Other practitioner office visit	\$65	After 1st three non-	0%	×
office or	Constallation to	005	preventive visits After 1st three non-	00/	
Cillic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	V
Teete	Laboratory Tests	\$40 40%	V	0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
	Tier 1	\$18	Pharmacy Deductible	0%	×
Drugs to	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	×
treat illness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	×
or containon	3	pharmacy deductible	Deductible	J /0	^
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
	Surgery facility fee (e.g., ASC)	40%	×	0%	X
Outpatient services	Physician/surgeon fees	40%	×	0%	×
	Outpatient visit	40%	×	0%	×
	Emergency room facility fee (waived if admitted)	40%	×	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need immediate	Medical transportation (including emergency and non-emergency)	40%	×	0%	×
attention					
	Urgent care	\$65	After 1st three non- preventive visits	0%	x
Henrital star	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	Х	0%	×
Hospital stay	Physician/surgeon fee	40%	×	0%	X
Mental	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-		
health, behavioral	visits	\$65	preventive visits	0%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$65	X	0%	×
abuse needs	items and services	φου	^	076	^
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	X	0%	X
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	X
recovering or other special	Skilled nursing care	40%	X	0%	x
health needs	Durable medical equipment	40%	Х	0%	×
	Hospice service	No charge		0%	X
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				
Child Day 1	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	5370104		1.51 5570,04	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	Not Covered		. tor covered	
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
COLVICES	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

_	_			_
Summary	∕ of	Benefits	and	Coverage

Summary of Benefits and Coverage					
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan			
Actuarial Value - A'	V Calculator				
	Plan design includes a deductible?	Yes, integrated			
	Integrated Individual deductible	\$8,700 <u>\$9,100</u> integrated			
Integrated Family deductible			\$17,400 <u>\$18,200</u> integrated		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	<u>\$8.7</u>	00 <u>\$9,100</u>		
Family Out-of-pocket maximum		\$17,400 <u>\$18,200</u>			
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	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		
clinic visit	Specialist visit	0%	X		
	Preventive care/ screening/ immunization	No charge			
	Laboratory Tests	0%	X		
Tests	X-rays and Diagnostic Imaging	0%	X		
	Imaging (CT/PET scans, MRIs)	0%	X		
	Tier 1	0%	Х		
Drugo to	Tier 2	0%	×		
Drugs to treat illness	T. 0	201			
or condition	Tier 3	0%	Х		
	Tier 4	0%	×		
	Surgery facility fee (e.g., ASC)	0%	X		
Outpatient services	Physician/surgeon fees	0%	x		
Services	Outpatient visit	0%	x		
	Emergency room facility fee (waived if admitted)	0%	×		
	Emergency room physician fee (waived if admitted)	No charge			
Need	Medical transportation (including emergency and non-emergency)	0%	X		
immediate attention					
	Urgent care	0%	After 1st three non- preventive visits		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	×		
Troopital otay	Physician/surgeon fee	0%	x		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	0%	After 1st three non-		
behavioral health, or	visits		preventive visits		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	Х		
Pregnancy	Prenatal care and preconception visits	No charge			
	Home health care (cost share per visit)	0%	×		
	Outpatient Rehabilitation and Habilitation services	0%	×		
Help recovering or	Skilled nursing care	0%	×		
other special health needs	Durable medical equipment	0%	X		
	Hospice service	0%	×		
Child eye	Eye exam	No charge			
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X		
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and Preventive	Sealants per Tooth	Not Covered			
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered			
Services	Periodontal Maintenance Services	0040160			
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered			
	Prosthodontics				
Child	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered			

## Endnotes to Covered California 20222023 Patient-Centered Benefit Plan Designs

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

#### Notes:

- 1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 20222023 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 13971367.656; 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 20222023 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	Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
	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;
	Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
4	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 20222023 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.