Covered California 2023 Patient-Centered Benefit Plan Designs¹

Proposed

February 17, 2022

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

² Clerical adjustment made to Silver 70 Urgent Care cost share to \$35 on March 23, 2021

³ Updates made to Catastrophic Plan Out of Pocket maximum and deductibles to reflect federal final rule for 2022.

Date: May 20, 2021 February 17, 2022

Summary of Benefits and Coverage



	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only F	Platinum	Individual-only F	
	, , , , , , , , , , , , , , , , , , , ,	Coinsurance	Plan	Copay Pla	ın
Actuarial Value - A	V Calculator	91.6% <u>91.8</u>	<u>3%</u>	89.3% <u>89.8</u>	<u>8%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	•
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$		\$0/\$0/\$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$.0	\$0 / \$0 / \$0	0
	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 Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's office or	Other practitioner office visit	\$15		\$15	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
		ψυ		ψυ	
Drugs to	Tier 2	\$15		\$15	
treat illness or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%			
services				\$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 immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
Mental	Physician/surgeon fee Mental/behavioral health and substance use disorder outpatient office	10%		No charge	
health, behavioral health, or	visits	\$15		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or other special	Skilled nursing care	10%		\$150 per day up to	
health needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
01.11.1	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	12 2/10.90		90	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive		No charge		No charge	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Pantal	Space Maintainers - Fixed			Co. 2000 0000	
Child Dental Basic	Restorative Procedures	20%		See 2022 2023 Dental Copay	
	Periodontal Maintenance Services			Schedule	
Services	r enodorital Maintenance Services				
Services	Crowns and Casts				
Services Child Dental				See- 2022- 2023	
Child Dental Major	Crowns and Casts	50%		Dental Copay	
Child Dental	Crowns and Casts Endodontics	50%			
Child Dental Major	Crowns and Casts Endodontics Periodontics (other than maintenance)	50%		Dental Copay	

	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	Ĭ
ctuarial Value - A	V Calculator	90.5% <u>90.7</u>	<u>%</u>	88.3% <u>88.8</u>	<u>8%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0/\$0/\$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
_	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Haaldh aana	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's office or	Other practitioner office visit	\$15		\$20	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat illness	Tier 2	\$25		\$20	
or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpations	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	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			\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
ognarioy	Home health care (cost share per visit)	-		-	
		10%		\$20	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
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	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	9		9	
	Preventive - Cleaning				
Child Dental	,				
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	
	Periodontics (other than maintenance)	50%		Dental Copay	
Major					1
Major Services	Prosthodontics			Schedule	
	Prosthodontics Oral Surgery			Schedule	

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
	Colorlator	04.00/		70.00/.00.4	107
tuarial Value - AV	Plan design includes a deductible?	81.9% No		78.0% <u>80.1</u> No	<u>176</u>
	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	\$8,200 <u>\$8,5</u> 9	<u>50</u>	\$8,200 <u>\$8,5</u>	<u>550</u>
	Family Out-of-pocket maximum	\$16,400 <u>\$17,</u>	<u>100</u>	\$16,400 <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)	20% 25%		\$150 <u>\$75</u>	
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$55 <u>\$60</u>		\$ 55 <u>\$60</u>	
treat illness or condition	Tier 3	\$80 <u>\$85</u>		\$80 <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	Physician/surgeon fees	20%		\$40	
services	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	Medical transportation (including emergency and non-emergency)	\$250		\$250	
immediate	modelar danaportation (modeling emergency and non-emergency)	Ψ230		Ψ230	
attention	Urgent care	\$35		\$35	
				#COO #250 d	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20% 30%		\$600 \$350 per day up to 5 days	
noopital olay	Physician/surgeon fee	20% 30%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$35		\$35	
abuse needs	items and services			·	
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	20% 30%		\$300 \$150 per day up to 5 days	
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				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	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 Dontal	Periodontics (other than maintenance)	50%		See-2022-2023 Dental Copay	
Child Dental Maior		0070		Donia Oupay	
Major Services				Schedule	
Major	Prosthodontics Oral Surgery			Schedule	

	refits and Coverage	CCSB-only		CCSB-only		
•	amounts describe the Enrollee's out of pocket costs.	Gold		Gold		
member duct dilare	anounce decorate and Employee ext. or position decor.	Coinsurance Plan		Copay Plan		
Actuarial Value - A	V Calculator	78.0% <u>79.0%</u>		79.4% <u>80.5%</u>		
	Plan design includes a deductible?	Yes, Medical/Pharm	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	.,		Applies		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 treat illness	Tier 2	\$50		\$40		
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	Х	
Outpatient services	Physician/surgeon fees	20%		\$35		
561 11665	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	medical transportation (modeling office) and reflection of the second	2070	^	Ψ230	^	
attention	Userstone					
	Urgent care	\$25		\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
Hospital stay	delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	Х	
	Physician/surgeon fee	20%	X	No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office	¢or.		\$35		
health, behavioral	visits	\$25		φ35		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	005		005		
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	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
recovering or	Skilled nursing care	20%	×	\$300 per day up to 5 days	Х	
other special health needs						
	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	No charge		No charge		
and Preventive	Sealants per Tooth	. to salargo		. 13 Silaigo		
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures			See 2022-2023 Dental Copay		
Basic Services	Periodontal Maintenance Services	20%		Schedule Schedule		
	Crowns and Casts					
	Endodontics					
Child Dental		500/		See-2022-2023 Dental Copay		
Major Services	Periodontics (other than maintenance)	50%		Schedule		
	Prosthodontics					
Ch:11	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		

Summary of Benefits and Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Plan
tuarial Value - A'	V Calculator	71.1% <u>71.6%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	E / CO
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 <u>\$4,750</u> / \$10 <u>\$8</u> \$7,400 <u>\$9,500</u> / \$ 20 <u>\$1</u>	
	Individual Out-of-pocket maximum	\$ 8,200 \$8,750	<u>/ U</u> / ΨU
	Family Out-of-pocket maximum	\$16,400 <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	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$45</u>	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$70	
Cillic Visit	'		
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 <u>\$50</u>	
rests		\$85 <u>\$95</u>	
	Imaging (CT/PET scans, MRIs)	\$325	Phores
	Tier 1	\$15 <u>\$16</u>	Pharma deductib
Drugs to	Tier 2	\$55 <u>\$60</u>	Pharma
treat illness	Time	000.000	deductib Pharma
or condition	Tier 3	\$85	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20%	doddollo
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	\$35 <u>\$45</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20% 30%	Х
Hospital stay	delivery, mental health, and substance use)		^
	Physician/surgeon fee	20% 30%	
Mental 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)	\$45	
Heln	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or	Skilled nursing care	20% 30%	х
other special health needs			^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	3	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	200/	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
01.11.1.5	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		

Date: May 20, 2021 February 17, 2022
Summary of Benefits and Coverage

Summary of Benefits and Coverage		CCSB-only Silver		CCSB-only Silver		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan		Copay Plan		
Actuarial Value - A	V Calculator	71.4% <u>71.9%</u>		70.8% <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	/ d o	N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 <u>\$2,500</u> / \$300		\$2,250 \$2,500 / \$300		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$4,500 <u>\$5,000</u> / \$600 \$ 8,200 <u>\$8,600</u>	7 \$0	\$4,500 \$5,000 / \$600 \$8,200 \$8,750	17 \$0	
	Family Out-of-pocket maximum	\$16,400 <u>\$17,200</u>		\$16,400 \$17,500		
	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	
	Primary care visit to treat an injury, illness, or condition	\$ 50 \$ <u>55</u>		\$55		
Health care provider's	Other practitioner office visit	\$50		\$55		
office or clinic visit	Specialist visit	\$85 \$90		\$90		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$50 \$55		\$55		
Tests	X-rays and Diagnostic Imaging	\$85 \$90		\$90		
	Imaging (CT/PET scans, MRIs)	30% 35%	Х	\$300	Х	
			A	·	Α	
	Tier 1	\$ 17 <u>\$20</u>		\$17 <u>\$19</u>		
Drugs to	Tier 2	\$70 <u>\$75</u>	Pharmacy deductible	\$80 <u>\$85</u>	Pharmacy deductible	
treat illness or condition	Tier 3	\$100 <u>\$105</u>	Pharmacy	\$110	Pharmacy	
		30% up to \$250 per script after	deductible Pharmacy	30% up to \$250 per script after	deductible Pharmacy	
	Tier 4	pharmacy deductible	deductible	pharmacy deductible	deductible	
	Surgery facility fee (e.g., ASC)	30%- 35%	Х	30% 35%	Х	
Outpatient services	Physician/surgeon fees	30%- 35%		30%		
	Outpatient visit	30% 35%		30%		
	Emergency room facility fee (waived if admitted)	30% 35%	X	30%	Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate	Medical transportation (including emergency and non-emergency)	30% 35%	X	30%	Х	
attention						
	Urgent care	\$ 50 <u>\$55</u>		\$55		
Harrist of a	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30% 35%	Х	30% 40%	Х	
Hospital stay	Physician/surgeon fee	30% 35%	Х	30% 40%		
Mental	Mental/behavioral health and substance use disorder outpatient office					
health, behavioral	visits	\$50		\$55		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$50		\$55		
abuse needs	items and services	φου <u>σου</u>		φοσ		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	30% 35%		\$45		
Help	Outpatient Rehabilitation and Habilitation services	\$50 <u>\$55</u>		\$55		
recovering or other special	Skilled nursing care	30% 35%	X	30% 40%	Х	
health needs	Durable medical equipment	30% 35%		30% 40%		
	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	No oborgo		No shares		
and Preventive	Sealants per Tooth	No charge		No charge		
	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					
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	50%		See-2022-2023 Dental Copay Schedule		
Services	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		
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2022 2023 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021 February 17, 2022

	2021 February 17, 2022		
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-or Silver HDHP Pl	
		HUHF FI	ali
Actuarial Value - A		71.8% <u>71</u>	
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible Integrated Family deductible	\$ 2,500 \$2,700 i \$ 5,000 \$5,400 i	-
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$6,850 <u>\$7</u>	,200
	Family Out-of-pocket maximum	\$ 13,700 <u>\$1</u>	<u>4,400</u>
	HSA family plan: Individual deductible		
Common	HSA family plan: Individual deductible	See endi	lote
Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	20% <u>25%</u>	X
Health care provider's	Other practitioner office visit	20% <u>25%</u>	x
office or clinic visit	Specialist visit	20% <u>25%</u>	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20% <u>25%</u>	Х
Tests	X-rays and Diagnostic Imaging	20% <u>25%</u>	х
	Imaging (CT/PET scans, MRIs)	20% <u>25%</u>	х
	Tier 1	20% 25% up to \$250	x
		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	x
	Surgery facility fee (e.g., ASC)	20% 25%	X
Outpatient	Physician/surgeon fees	20% 25%	X
services	Outpatient visit	20% 25%	X
	Emergency room facility fee (waived if admitted)	20% 25%	X
	Emergency room physician fee (waived if admitted)	0%	X
Need	Medical transportation (including emergency and non-emergency)	20% 25%	x
immediate attention			
	Urgent care	20% 25%	x
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20% 25%	x
nospital stay	Physician/surgeon fee	20% 25%	х
Mental	Mental/behavioral health and substance use disorder outpatient office	20% 25%	×
health, behavioral	visits	2070 2070	^
health, or substance	Mental/behavioral health and substance use disorder other outpatient	20% 25%	x
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20% 25%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	20% 25%	X
other special	Skilled nursing care	20% 25%	Х
health needs	Durable medical equipment	20% 25%	X
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	_	
	Topical Fluoride Application		
OLU LE	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics	F00/	
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics Oral Surgery		
Child	Oral Surgery		
Orthodontics	Medically necessary orthodontics	50%	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
.t	V Colorina	04.70/.04	00/	07.00/.07.00/	
tuarial Value - A'	V Calculator Plan design includes a deductible?	94.7% <u>94</u> Yes, Medical/F		87.8% 87.9% Yes, Medical/Pharm	and the second
	Integrated Individual deductible	N/A	Паппасу	N/A	lacy
	Integrated Family deductible	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/ \$0 <u>\$50</u> / \$	60
	Individual Out-of-pocket maximum	\$800 <u>\$9</u>	100	\$ 2,850 <u>\$3,000</u>	
	Family Out-of-pocket maximum	\$1,600 <u>\$1</u>	<u>,800</u>	\$ 5,700 <u>\$6,000</u>	
	HSA plan: Self-only coverage deductible	N/A N/A		N/A N/A	
Common	HSA family plan: Individual deductible		- · · · · ·	IV/A	5
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	
	Tier 1	\$3		\$5	Pharmacy deductible
Drugs to	Tier 2	\$10		\$25	Pharmacy deductible
treat illness or condition	Tier 3	\$15		\$45	Pharmacy
	Tier 4	10% up to \$150 per		15% up to \$150 per script	deductible Pharmacy
		script			deductible
Outpatient	Surgery facility fee (e.g., ASC)	10%		15%	
services	Physician/surgeon fees	10%		15%	
	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	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention					
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	Х	15% 25%	Х
Mental	Physician/surgeon fee Mental/behavioral health and substance use disorder outpatient office	10%		15% 25%	
health, behavioral	visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	15% 25%	X
other special health needs			^		^
	Durable medical equipment	10%		15%	
	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				
Child Dantal	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
23111303	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%			

ummary of Bei	nefits and Coverage		
-	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	-
ctuarial Value - A	W Calculator	73.4% <u>73.5%</u>	
Stuariai Value - A	Plan design includes a deductible?	Yes, Medical/Pharm	1204
	Integrated Individual deductible	N/A	iacy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 <u>\$4,750</u> / \$10 <u>\$</u>	<u>85</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 <u>\$9,500</u> / \$20 <u>\$1</u>	<u>70</u> / \$0
	Individual Out-of-pocket maximum	\$6,300 <u>\$7,250</u>	
	Family Out-of-pocket maximum	\$12,600 <u>\$14,500</u>	<u>)</u>
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$45</u>	
Health care provider's	Other practitioner office visit	\$35 <u>\$45</u>	
office or	·	φου <u>φ.ιο</u>	
clinic visit	Specialist visit	\$70 <u>\$85</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40 <u>\$50</u>	
Tests	X-rays and Diagnostic Imaging	\$ 85 <u>\$90</u>	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	Pharma deductib
	Tier 2	\$55	Pharma
Drugs to treat illness			deductib Pharma
or condition	Tier 3	\$85	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
0	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 immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35 <u>\$45</u>	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20% 30%	X
Mental		20% 30%	
health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$35 <u>\$45</u>	
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	
Help .	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$45</u>	
recovering or other special	Skilled nursing care	20% 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	g-	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and		No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Day	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plat	n
				none Flai	1
Actuarial Value - A	V Calculator	64.8% <u>64.5%</u>		64.6% <u>64.2</u>	<u>%</u>
	Plan design includes a deductible?	Yes, Medical/Pharr	macy	Yes, integrat	
	Integrated Individual deductible Integrated Family deductible	N/A N/A		\$7,000 integra \$14,000 integra	
	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 Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Lvein	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	Х
Health care	Other practitioner office visit	\$65	After 1st three non-	0%	x
provider's office or		φου	preventive visits After 1st three non-	0%	
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tosts	Laboratory Tests	\$40	.,	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%	X
Drugs to	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
treat illness 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%	Х	0%	Х
	Outpatient visit	40%	Х	0%	Х
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need immediate attention	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
	Urgent care	\$65	After 1st three non- preventive visits	0%	х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	40% 40%	X X	0%	X X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	Х
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	X	0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	Х	0%	х
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	х
recovering or other special	Skilled nursing care	40%	X	0%	Х
health needs	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	х
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Ohitto	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 Glarge		140 Glaige	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
A. F.	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

Summary of	Benefits ar	nd Coverage
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Member Cost Share amounts describe the Enrollee's out of pocket costs.		Catastrophic Plan		
Actuarial Value - A	V Calculator			
Actuariai Value - A	Plan design includes a deductible?	Yes,	integrated	
	Integrated Individual deductible		9,100 integrated	
	Integrated Family deductible	\$17,400 <u>\$</u>	8,200 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	#0. 7	N/A	
	Individual Out–of–pocket maximum Family Out-of-pocket maximum		00 <u>\$9,100</u> 00 <u>\$18,200</u>	
	HSA plan: Self-only coverage deductible	Ψ17,1	N/A	
	HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits	
Health care provider's	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%	x	
Tests	X-rays and Diagnostic Imaging	0%	x	
	Imaging (CT/PET scans, MRIs)	0%	x	
	Tier 1	0%	X	
	Time			
Drugs to treat illness	Tier 2	0%	X	
or condition	Tier 3	0%	Х	
	Tier 4	0%	X	
	0 (- 1111 / - / 400)			
Outpatient	Surgery facility fee (e.g., ASC)	0%	X	
services	Physician/surgeon fees	0%	X	
	Outpatient visit Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	No charge	^	
Need	Medical transportation (including emergency and non-emergency)	0%	X	
immediate attention	modela transportation (modeling emergency and non-emergency)	078	^	
attention	Urgent care	0%	After 1st three non-	
		070	preventive visits	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	X	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	X	
Mental		078		
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits	
health, or	Mental/behavioral health and substance use disorder other outpatient			
substance 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%	Х	
recovering or other special	Skilled nursing care	0%	Х	
health needs	Durable medical equipment	0%	Х	
	Hospice service	0%	Х	
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray	No charge		
Preventive	Sealants per Tooth			
	Topical Fluoride Application			
Child Dental	Space Maintainers - Fixed			
Basic	Restorative Procedures	0%	Х	
Services	Periodontal Maintenance Services			
	Crowns and Casts			
Child Dental	Endodontics Periodontics (ether than maintenance)	0%	X	
Major Services	Periodontics (other than maintenance) Prosthodontics	U%	^	
	Prostnodontics Oral Surgery			
Child	• •	001		
Orthodontics	Medically necessary orthodontics	0%	X	

Date: May 20, 2021 February 17, 2022

Summary of Benefits and Coverage



mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Platinum Coinsurance Plan		Individual-only Platinum Copay Plan	
tuarial Value - A'	V Calculator	91.6% <u>91.8</u>	<u>8%</u>	89.3% <u>89.8</u>	<u>%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	·		\$9,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common	HOA fairing plant. Individual deductible				
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
Health 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		\$30	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$15		No charge \$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
. 50.3					
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Orugs to	Tier 2	\$15		\$15	
reat illness	Tier 3	#0 5		# 0=	
or condition	Her 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g. ASC)	·		·	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
services	Physician/surgeon fees	10%		\$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 mmediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention					
	Urgent care	\$15		\$15	
	Facility foe (e.g. hospital room) for innations atout final after the con-			\$250 par	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
, c.u,	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	¢4 <i>E</i>		¢4 <i>E</i>	
nealth, pehavioral	visits	\$15		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	€ 4 <i>E</i>		¢4 <i>E</i>	
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	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
ecovering or	Skilled nursing care	10%		\$150 per day up to	
other special nealth needs	Durable medical equipment	10%		5 days 10%	
	Hospice service				
		No charge		No charge	
Child eye care	Logic of alcoholo per year (or contact logges in liquid algebra)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	o. covereu		Govereu	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child					

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	Ĭ
tuarial Value - A	V Calculator	90.5% <u>90.7</u>	<u>%</u>	88.3% <u>88.8</u>	<u>8%</u>
	Plan design includes a deductible?	No	_	No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$6)	\$0/\$0/\$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$6	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or					
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	
		φί		φο	
Drugs to	Tier 2	\$25		\$20	
treat illness or condition	Tier 3	\$40		\$30	
o, condition					
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
Need	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$150		\$150	
mmediate attention					
	Urgent care	\$15		\$20	
	organical care	φισ		φ20	
	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	100/		5 days	
Mantal	rnysidal/surgeon ree	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
behavioral health, or	Viole				
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
abuse needs					
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	
health needs	Durable medical equipment	10%		5 days 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	N. C			
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
	eral calgory				

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	d'
	W0.1.1	04.00/		70.00/.00	10/
tuarial Value - A	v Calculator Plan design includes a deductible?	81.9% No		78.0% <u>80.1</u> No	<u>1%</u>
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$	60
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$	60
	Individual Out-of-pocket maximum	\$ 8,200 <u>\$8.5</u> 5	<u>50</u>	\$ 8,200 <u>\$8,5</u>	<u>550</u>
	Family Out-of-pocket maximum		<u>100</u>	\$16,400 <u>\$17</u>	<u>,100</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common	TISA family plant. Individual deductible				
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's	Other practitioner office visit	\$35		\$35	
office or clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20% 25%		\$ 150 \$75	
	Tier 1	\$15		\$15	
Drugs to treat illness	Tier 2	\$ 55 <u>\$60</u>		\$55 <u>\$60</u>	
or condition	Tier 3	\$80 <u>\$85</u>		\$80 <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	Medical transportation (including emergency and non-emergency)	\$250		\$250	
mmediate attention					
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$600 \$350 per day	
Hospital stay	delivery, mental health, and substance use)	20% 30%		up to 5 days	
	Physician/surgeon fee	20% 30%		No charge	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Holp	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
Help recovering or	Skilled nursing care	20% 30%		\$300 \$150 per day	
other special health needs	Durable medical equipment	20%		up to 5 days 20%	
	Hospice service				
		No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
OLULD	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	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

	Summary of Benefits and Coverage			CCSB-only		
-	amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		Gold		
monipor door chare	amounto deconde and Emones of the position decon.	Coinsurance Plan	n	Copay Plan		
Actuarial Value - A	V Calculator	78.0% <u>79.0%</u>		79.4% <u>80.5%</u>		
notaanai vaido 70	Plan design includes a deductible?	Yes, Medical/Pharma	acv	Yes, Medical/Pharr	nacy	
	Integrated Individual deductible	N/A	асу	N/A	пасу	
	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 HSA family plan: Individual deductible	N/A N/A		N/A N/A		
Common	. To Training plant matrices a section of			. 47.1		
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Event						
	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		
		υισ		ψιυ		
Drugs to	Tier 2	\$50		\$40		
treat illness or condition	Tier 3	\$80		\$70		
		400		ψ. σ		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300	Х	
Outpatient		20%			^	
services	Physician/surgeon fees			\$35		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х	
immediate attention						
	Urgent care	\$25		\$35		
				·		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
Hospital stay	delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	Х	
	Physician/surgeon fee	20%	Х	No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office	005		405		
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 ove	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	. to s.iai go		. 10 0.10190		
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
and Preventive	Sealants per Tooth					
	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		N .				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		

9.5 EHB

Tests

Drugs to treat illness or condition

Outpatient services

Need

immediate attention

Hospital stay

Mental

behavioral health, or

substance

abuse needs

Pregnancy

Help recovering or

other special health needs

Child eye care

Child Dental

Diagnostic and

Preventive

Child Dental Basic

Child Dental Major

Services

Child Orthodonti

Services

20, 2021 Fobruary 17, 2022

Laboratory Tests

Tier 1

Tier 2

Tier 3

Tier 4

X-rays and Diagnostic Imaging

Imaging (CT/PET scans, MRIs)

Surgery facility fee (e.g., ASC)

Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted)

Medical transportation (including emergency and non-emergency)

Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)

Mental/behavioral health and substance use disorder outpatient office

Mental/behavioral health and substance use disorder other outpatient

Physician/surgeon fees

Outpatient visit

Urgent care

Physician/surgeon fee

items and services

Skilled nursing care

Hospice service

Eye exam

Oral Exam

Preventive - Cleaning

Preventive - X-ray

Sealants per Tooth

Topical Fluoride Application Space Maintainers - Fixed

Periodontal Maintenance Services

Periodontics (other than maintenance)

Medically necessary orthodontics

Restorative Procedures

Crowns and Casts Endodontics

Prosthodontics Oral Surgery

Durable medical equipment

Prenatal care and preconception visits

Home health care (cost share per visit)

Outpatient Rehabilitation and Habilitation services

1 pair of glasses per year (or contact lenses in lieu of glasses)

Summary	v of	Benefits	and	Coverage
Oumman	,	Denenia	unu	Coverage

Date: May 20,	2021 <u>February 17, 2022</u>			
Summary of Ber	nefits and Coverage			
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Plan	
Actuarial Value - A	V Calculator	71.1% <u>71.6%</u>		
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	
	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>\$85</u> / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 <u>\$9,500</u> / \$20 <u>\$170</u> / \$0		
	Individual Out–of–pocket maximum	\$8, 200 \$8,750		
	Family Out-of-pocket maximum	\$16,400 <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	
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$45</u>		
Health care provider's office or	Other practitioner office visit	\$35 <u>\$45</u>		
clinic visit	Specialist visit	\$70 <u>\$85</u>		
	Preventive care/ screening/ immunization	No charge		

\$40 \$50

\$85 \$95

\$325

\$15 <u>\$16</u>

\$55 \$60

\$85 <u>\$90</u>

20% up to \$250 per script

after pharmacy deductible

20%

20%

No charge

\$250

\$35 \$45

20% 30%

20% 30%

\$35 <u>\$45</u>

\$35 <u>\$45</u>

No charge

\$45

\$35 <u>\$45</u>

20% 30%

20%

No charge

No charge

No charge

Not Covered

Not Covered

Not Covered

Not Covered

Pharmacy deductible

Pharmacv

deductible Pharmacy

deductible

Pharmacy

deductible

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Χ

	Summary of Benefits and Coverage		CCSB-only		CCSB-only		
-	amounts describe the Enrollee's out of pocket costs.	Silver		Silver Copay Plan			
	·	Coinsurance Plan	1	Copay Plan			
Actuarial Value - A	V Calculator	71.4% <u>71.9%</u>		70.8% <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	\$2,250 <u>\$2,500</u> / \$300	/ \$0	\$2,250 <u>\$2,500</u> / \$300	/\$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 4,500 <u>\$5,000</u> / \$600	/ \$0	\$4,500 <u>\$5,000</u> / \$600	/\$0		
	Individual Out-of-pocket maximum	\$8,200 <u>\$8,600</u>		\$ 8,200 <u>\$8,750</u>			
	Family Out-of-pocket maximum	\$16,400 <u>\$17,200</u>		\$16,400 <u>\$17,500</u>			
	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	Contract Type	Member dost chare	Applies	Member dost onare	Applies		
	Primary care visit to treat an injury, illness, or condition	\$ 5 0 <u>\$55</u>		\$55			
Health care	Other practitioner office visit	TEO TEE		¢==			
provider's office or	Other practitioner office visit	\$50 <u>\$55</u>		\$55			
clinic visit	Specialist visit	\$85 \$90		\$90			
	Preventive care/ screening/ immunization	No charge		No charge			
	Laboratory Tests	\$ 50 <u>\$55</u>		\$55			
Tests	X-rays and Diagnostic Imaging	\$85 <u>\$90</u>		\$90			
	Imaging (CT/PET scans, MRIs)	30% 35%	Х	\$300	Х		
				·			
	Tier 1	\$17 <u>\$20</u>		\$17 <u>\$19</u>			
Drugs to	Tier 2	\$ 70 <u>\$75</u>	Pharmacy deductible	\$80 <u>\$85</u>	Pharmacy deductible		
treat illness	Tier 3	\$400 \$40F	Pharmacy	M440	Pharmacy		
or condition	Hel 3	\$ 100 <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		
	0 (
Outpatient	Surgery facility fee (e.g., ASC)	30% 35%	X	30% 35%	Х		
services	Physician/surgeon fees	30% 35%		30%			
	Outpatient visit	30% 35%		30%			
	Emergency room facility fee (waived if admitted)	30% 35%	Х	30%	Х		
	Emergency room physician fee (waived if admitted)	No charge		No charge			
Need	Medical transportation (including emergency and non-emergency)	30% 35%	Х	30%	х		
immediate attention							
	Urgent care	\$ 50 \$ <u>55</u>		\$55			
		φου <u>φου</u>		ψου			
	Facility fee (e.g. hospital room) for inpatient stay (including labor and						
Hospital stay	delivery, mental health, and substance use)	30% 35%	Х	30% 40%	Х		
, ,	Physician/surgeon fee	30% 35%	Х	30% 40%			
Mental	Mental/behavioral health and substance use disorder outpatient office						
health, behavioral	visits	\$50 \$55		\$55			
health, or	Mental/behavioral health and substance use disorder other outpatient						
substance abuse needs	items and services	\$50 \$55		\$55			
Pregnancy	Prenatal care and preconception visits	No charge		No charge			
	Home health care (cost share per visit)	30% 35%		\$45			
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$50 <u>\$55</u>		\$55			
other special	Skilled nursing care	30% 35%	X	30% 40%	Х		
health needs	Durable medical equipment	30% 35%		30% 40%			
	Hospice service	No charge		No charge			
Child eye	Eye exam	No charge		No charge			
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge			
	Oral Exam						
	Preventive - Cleaning						
Child Dental	-						
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered			
Preventive	Sealants per Tooth						
	Topical Fluoride Application						
	Space Maintainers - Fixed						
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered			
Services	Periodontal Maintenance Services	Not Covered		Not Covered			
	Crowns and Casts						
	Endodontics						
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered			
Services		1101 0070100		1101 0010100			
	Prosthodontics						
Ol "I	Oral Surgery						
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered			

-	Senefits and Coverage are amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	
tuarial Value	AV Calculator	71.8% <u>71</u>	<u>.1%</u>
	Plan design includes a deductible?	Yes, integr	rated
	Integrated Individual deductible	\$ 2,500 <u>\$2,700</u> i	ntegrated
	Integrated Family deductible	\$5,000 <u>\$5,400</u> i	ntegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	000
	Individual Out–of–pocket maximum Family Out-of-pocket maximum	\$6,850 <u>\$7</u> \$13,700 <u>\$1</u>	
	HSA plan: Self-only coverage deductible	\$ 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	20% <u>25%</u>	х
Health care provider's	Other practitioner office visit	20% <u>25%</u>	X
office or clinic visit	Specialist visit	20% <u>25%</u>	×
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20% 25%	X
Tests	X-rays and Diagnostic Imaging	20% <u>25%</u>	X
	Imaging (CT/PET scans, MRIs)	20% <u>25%</u>	X
	Tier 1	20% 25% up to \$250	X
		per script	, x
Drugs to	Tier 2	20% 25% up to \$250 per script	X
treat illness or condition	Tier 3	20% 25% up to \$250	x
		per script 20% 25% up to \$250	
	Tier 4	per script	X
	Surgery facility fee (e.g., ASC)	20% 25%	X
Outpatient services	Physician/surgeon fees	20% 25%	X
	Outpatient visit	20% 25%	X
	Emergency room facility fee (waived if admitted)	20% 25%	X
	Emergency room physician fee (waived if admitted)	0%	X
Need immediate attention	Medical transportation (including emergency and non-emergency)	20% 25%	х
	Urgent care	20% 25%	х
Hospital stay		20% 25%	Х
	Physician/surgeon fee	20% 25%	X
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	20% 25%	Х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20% 25%	x
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	20% 25%	х
Help	Outpatient Rehabilitation and Habilitation services	20% 25%	Х
recovering on ther specia	Skilled nursing care	20% 25%	Х
health needs	Durable medical equipment	20% 25%	Х
	Hospice service	0%	Х
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	Not Covered	
and Preventive	Sealants per Tooth	Mor Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	1401 Covered	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
	V Caladata	04.70/.04	00/	07.00/.07.00/	
tuarial Value - A\	V Calculator Plan design includes a deductible?	94.7% <u>94</u> Yes, Medical/F		87.8% 87.9% Yes, Medical/Pharm	acv.
	Integrated Individual deductible	N/A	Паппасу	N/A	lacy
	Integrated Family deductible	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/ \$0 <u>\$50</u> / \$	60
	Individual Out-of-pocket maximum	\$ 800 <u>\$9</u>	100	\$ 2,850 <u>\$3,000</u>	
	Family Out-of-pocket maximum	\$1,600 <u>\$1</u>	<u>,800</u>	\$ 5,700 <u>\$6,000</u>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$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	
	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 script		15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	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	ed Medical transportation (including emergency and non-emergency) \$30 \$75				
immediate attention	modela transportation (modeling emergency and non-emergency)	φ30			
attention	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	X	15% 25%	Х
Mental	Physician/surgeon fee Mental/behavioral health and substance use disorder outpatient office	10%		15% 25%	
health, behavioral health, or	visits	\$5		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	15% 25%	×
other special health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	0010100			
	Crowns and Casts				
Child Dontal	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major					
Services	Prosthodontics				

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan		
561 5031 511818	amounts accorded the Enterior of out of pounds cooles.	200%-250% FPL	-	
tuarial Value - A\	V Calculator	73.4% <u>73.5%</u>		
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	
	Integrated Individual deductible	N/A	•	
	Integrated Family deductible	N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 <u>\$4,750</u> / \$10 <u>\$85</u> / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 <u>\$9,500</u> / \$20 <u>\$1</u>	<u>70</u> / \$0	
	Individual Out–of–pocket maximum	\$6,300 <u>\$7,250</u>		
	Family Out-of-pocket maximum	\$ 12,600 <u>\$14,500</u>	<u>)</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	¢25 ¢45		
Health care	Filmary care visit to treat an injury, illness, or condition	\$35 <u>\$45</u>		
orovider's	Other practitioner office visit	\$35 <u>\$45</u>		
office or clinic visit	Specialist visit	\$70 <u>\$85</u>		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$4 0 <u>\$50</u>		
Гests	X-rays and Diagnostic Imaging	\$85 <u>\$90</u>		
	Imaging (CT/PET scans, MRIs)	\$325		
			Pharmac	
	Tier 1	\$15 <u>\$16</u>	deductibl	
Orugs to	Tier 2	\$55	Pharmad deductible	
reat illness or condition	Tier 3	\$85	Pharmad	
			deductibl	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmad 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	Medical transportation (including emergency and non-emergency)	_		
immediate	medical transportation (including energency and non-energency)	\$250		
attention		00-04-		
	Urgent care	\$35 \$45		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			
Hospital stay	delivery, mental health, and substance use)	20% 30%	X	
	Physician/surgeon fee	20% 30%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35 <u>\$45</u>		
behavioral	visits			
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35 <u>\$45</u>		
abuse needs				
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$40		
Help	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$45</u>		
recovering or other special	Skilled nursing care	20% 30%	Х	
nealth needs	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye	Eye exam	No charge		
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam	3.		
	Preventive - Cleaning			
Child Dental	Preventive - X-ray			
Diagnostic and		Not Covered		
Preventive	Sealants per Tooth Topical Fluoride Application			
	Topical Fluoride Application			
Child Dantal	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services			
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	Not Covered		
001 VIUES	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	Not Covered		

-	nefits and Coverage	Prenze Plen		Bronze	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		HDHP Pla	n
Actuarial Value - A	V Calculator	64.8% <u>65.4%</u>		64.6% <u>64.2</u>	<u>%</u>
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integra	ted
	Integrated Individual deductible	N/A		\$7,000 integra	
	Integrated Family deductible	N/A	20	\$14,000 integr	rated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$ \$12,600 / \$1,000		N/A N/A	
	Individual Out-of-pocket maximum	\$8,200	Ψ	See endno	te
	Family Out-of-pocket maximum	\$16,400		See endno	
	HSA plan: Self-only coverage deductible	N/A		\$7,000	
	HSA family plan: Individual deductible			\$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%	x
office or			preventive visits After 1st three non-	004	
CIIIIC VISIL	Specialist visit	\$ 95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$40	V	0%	X
10313	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
	Tier 1	\$18	Pharmacy Deductible	0%	X
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 deductible	Pharmacy Deductible	0%	x
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
0.4	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient services	Physician/surgeon fees	40%	X	0%	X
	Outpatient visit	40%	X	0%	X
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need immediate attention	Medical transportation (including emergency and non-emergency)	40%	X	0%	Х
	Urgent care	\$65	After 1st three non- preventive visits	0%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	40% 40%	X X	0%	X X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	х
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	×	0%	x
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%	×
recovering or	Skilled nursing care	40%	X	0%	X
other special health needs	Durable medical equipment	40%	X	0%	×
	Hospice service	No charge		0%	X
Child	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				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	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	
20111003	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics	,	1101 0070100		. 101 0070160	

Summary	f	Ronofite	and	Coverage
Summarv	OI.	benefits	and	Coverage

Summary of Benefits and Coverage					
Member Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan		
Actuarial Value -					
	Plan design includes a deductible? Integrated Individual deductible	Yes, integrated \$8,700 \$9,100 integrated			
	Integrated Framily deductible		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	\$8,7	'00 <u>\$9,100</u>		
	Family Out-of-pocket maximum	\$17,4	00 <u>\$18,200</u>		
	HSA plan: Self-only coverage deductible		N/A		
Common	HSA family plan: Individual deductible		N/A		
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	i filinary care visit to treat arrinjury, liliess, or containor	0 /6	preventive visits		
provider's office or	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%	X		
	Tion 2	001	, , , , , , , , , , , , , , , , , , ,		
Drugs to treat illness	Tier 2	0%	X		
or condition	Tier 3	0%	X		
	Tier 4	0%	X		
		-,,			
Outpatient	Surgery facility fee (e.g., ASC)	0%	X		
services	Physician/surgeon fees	0%	X		
	Outpatient visit	0%	X		
	Emergency room facility fee (waived if admitted)	0%	X		
	Emergency room physician fee (waived if admitted)	No charge			
Need immediate	Medical transportation (including emergency and non-emergency)	0%	X		
attention			After 1st three near		
	Urgent care	0%	After 1st three non- preventive visits		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Physician/surgeon fee	0%	x		
Mental	Mental/behavioral health and substance use disorder outpatient office	0%	After 1st three non-		
health, behavioral	visits	U7 ₀	preventive visits		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	×		
abuse needs	items and services	070	^		
Pregnancy	Prenatal care and preconception visits	No charge			
	Home health care (cost share per visit)	0%	X		
Help	Outpatient Rehabilitation and Habilitation services	0%	X		
recovering of other special	Skilled nursing care	0%	X		
health needs	Durable medical equipment	0%	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)	0%	X		
	Oral Exam				
Child Day	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered			
and Preventive	Sealants per Tooth	not covered			
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered			
Services	Periodontal Maintenance Services	OUVUIGU			
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered			
Get vices	Prosthodontics				
	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:

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

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

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

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