Covered California 2023 2024 Patient-Centered Benefit Plan Designs¹

Final Board-approved

Proposed

Final AV Calculator and

Notice of Benefit and Payment Parameters for 2024 Final Rule

June 16, 2022 April 20, 2023

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

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Date: June 16, 2022 April 20, 2023

Summary of Benefits and Coverage

| | amounts describe the Enrollee's out of pocket costs. | Coinsurance | Plan | Copay Pla | in |
|------------------------------|--|------------------------------|------------|--|--------|
| tuarial Value - A | V Calculator | 91.8% <u>91.9</u> | <u>9%</u> | 89.8% 90.7 | % |
| | 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 |
| | Individual Out–of–pocket maximum | \$4,500 | | \$4,500 | |
| | Family Out-of-pocket maximum | \$9,000 | | \$9,000 | |
| | HSA plan: Self-only coverage deductible HSA family plan: Individual deductible | N/A N/A | | N/A N/A | |
| Common Medical | Service Type | Member Cost | Deductible | Member Cost | Deduct |
| Event | | Share | Applies | Share | Applie |
| Health care | Primary care visit to treat an injury, illness, or condition | \$15 | | \$15 | |
| provider's | Other practitioner office visit | \$15 | | \$15 | |
| clinic visit | Specialist visit | \$30 | | \$30 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests | \$15 | | \$15 | |
| lests | X-rays and Diagnostic Imaging | \$30 | | \$30 | |
| | Imaging (CT/PET scans, MRIs) | 10% | | \$75 | |
| | Tier 1 | \$5 \$7 | | \$5 \$7 | |
| | | ψυψι | | ψυψι | |
| Drugs to | Tier 2 | \$15 \$16 | | \$15 \$16 | |
| reat illness or condition | Tier 3 | \$25 | | \$25 | |
| | - | 10% up to \$250 per | | 10% up to \$250 per | |
| | Tier 4 | script | | script | |
| | Surgery facility fee (e.g., ASC) | 10% | | \$100 \$75 | |
| Dutpatient 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 | Medical transportation (including emergency and non-emergency) | \$150 | | \$150 | |
| mmediate | | | | | |
| attention | Urgent care | \$15 | | \$15 | |
| | orgeni care | φισ | | φισ | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) | 10% | | \$250 \$225 per day up to 5 days | |
| Hospital stay | Physician/surgeon fee | 10% | | No charge | |
| Mental | Mental/behavioral health and substance use disorder outpatient office | | | | |
| nealth, behavioral | visits | \$15 | | \$15 | |
| health, 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 | |
| | | | | | |
| lelp ecovering or | Outpatient Rehabilitation and Habilitation services | \$15 | | \$15 \$150 \$125 per day | |
| other special | Skilled nursing care | 10% | | up to 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 | Sealants per Tooth | No charge | | No charge | |
| Preventive | Topical Fluoride Application | | | | |
| | | | | | |
| | Space Maintainers - Fixed | | | | |
| Child Dental Basic | Restorative Procedures | 20% | | See 2023 2024 Dental Copay | |
| Services | Periodontal Maintenance Services | | | Schedule | |
| | Crowns and Casts | | | | |
| Child Dental | Endodontics | | | See 2023 2024 | |
| | | = | 1 | | |
| Major Services | Periodontics (other than maintenance) | 50% | | Dental Copay | |
| Major Services | Periodontics (other than maintenance) Prosthodontics | 50% | | Dental Copay Schedule | |

50%

\$1,000

Child Orthodontics

Medically necessary orthodontics

| Health care provider's office or clinic visit Tests P Tests Drugs to treat illness or condition S Outpatient services Need immediate attention Hospital stay | Calculator Plan design includes a deductible? | | CCSB-only Platinum Coinsurance Plan | | ı In |
|--|--|-------------------------------|---|-------------------------------|--------------|
| Common Medical Event P Health care provider's office or clinic visit P Tests I Drugs to treat illness or condition T Drugs to treat illness or condition T Dutpatient services S Need immediate attention H Need immediate attention H | | | | | |
| Medical Event P Health care provider's office or clinic visit S P Tests 1 Drugs to treat illness or condition T T Outpatient services 2 Need immediate attention U | Plan design includes a deductible? | 90.7% <u>91.2</u> | <u>%</u> | 88.8% <u>89.4</u> | <u>.%</u> |
| Medical Event P Health care provider's office or clinic visit S P Tests 1 Drugs to treat illness or condition 1 T Dutpatient services 2 Need immediate attention U | - | No | | No | |
| Medical Event P Health care provider's office or clinic visit S P Tests 1 Drugs to treat illness or condition 1 T Dutpatient services 2 Need immediate attention U | Integrated Individual deductible | \$0 | | \$0 | |
| Medical Event P Health care provider's office or clinic visit S P Tests A Drugs to treat illness or condition T Drugs to treat illness or condition T Drugs to treat illness or condition T S Dutpatient services C Need M mmediate attention U | Integrated Family deductible | \$0 | <u>_</u> | \$0 | • |
| Medical Event P Health care provider's office or clinic visit S P Fests A Drugs to reat illness or condition T Drugs to reat illness or condition T Dutpatient S Services P C C Dutpatient S S P C C C C C C C C C C C C C C C C C | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$0 / \$0 / \$ | | \$0 / \$0 / \$ | |
| Medical Event P Health care provider's office or clinic visit S P Fests A Drugs to reat illness or condition T Drugs to reat illness or condition T Dutpatient S Services P C C Dutpatient S S P C C C C C C C C C C C C C C C C C | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$0 / \$0 / \$ | 0 | \$0 / \$0 / \$ | 0 |
| Medical Event P Health care provider's office or clinic visit S P Fests A Drugs to reat illness or condition T Drugs to reat illness or condition T Dutpatient S Services P C C Dutpatient S S P C C C C C C C C C C C C C C C C C | Individual Out-of-pocket maximum | \$4,500 | | \$4,500 | |
| Medical Event P Health care provider's office or clinic visit S P Fests A Drugs to reat illness or condition T Drugs to reat illness or condition T Dutpatient S Services P C C Dutpatient S S P C C C C C C C C C C C C C C C C C | Family Out-of-pocket maximum | \$9,000 | | \$9,000 | |
| Medical Event P Health care provider's office or clinic visit S P Tests A Drugs to treat illness or condition T Drugs to treat illness or condition T Drugs to treat illness or condition T S Dutpatient services C Need M mmediate attention U | HSA plan: Self-only coverage deductible | N/A N/A | | N/A N/A | |
| Health care provider's office or clinic visit Fests Drugs to creat illness or condition Dutpatient services Need mmediate attention Hospital stay | HSA family plan: Individual deductible Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deduo App |
| Provider's office or Sinic visit S P Fests I Drugs to reat illness or condition T Dutpatient services P C Dutpatient S P C C Dutpatient S S C C C C C C C C C C C C C C C C C C | Primary care visit to treat an injury, illness, or condition | \$15 | | \$20 | |
| Solution of the second state of the second sta | | | | | |
| Heed Heed Heed Heed Heed heed | Other practitioner office visit | \$15 | | \$20 | |
| Fests I I I I X I X I I X I X I I X I X I X | Specialist visit | \$30 | | \$30 | |
| Tests I I I I X I X I I X I X I I X I X I I X | Preventive care/ screening/ immunization | No charge | | No charge | |
| Tests A X In Tests I | Laboratory Tests | \$15 | | \$20 | |
| Veed mediate titention Hospital stay | | | | | |
| Porugs to reat illness or condition Putpatient ervices Reed mmediate titention Hospital stay | K-rays and Diagnostic Imaging | \$30 | | \$30 | |
| Drugs to reat illness or condition T Dutpatient ervices E Reed mediate titention U | maging (CT/PET scans, MRIs) | 10% | | \$100 | |
| Vutpatient vervices Vervices | Fier 1 | \$10 | | \$5 | |
| Vutpatient services Need mediate tittention | Fior 2 | * ~~ | | * ~~ | |
| Precondition T putpatient ervices P C P C P C C C C C C C C C C C C C | Fier 2 | \$25 | | \$20 | |
| Aveed mmediate ttention U | Fier 3 | \$40 | | \$30 | |
| Dutpatient services P Services C Reed mmediate tittention E Notest F Hospital stay F | Fier 4 | 10% up to \$250 per script | | 10% up to \$250 per script | |
| Dutpatient services P Services C Reed mmediate tittention E Notest F Hospital stay F | Surgery facility fee (e.g., ASC) | 10% | | \$100 | |
| Veed Mammediate Hospital stay | | | | | |
| Need mmediate tittention U | Physician/surgeon fees | 10% | | \$25 | |
| Need Memediate Hittention U | Dutpatient visit | 10% | | 10% | |
| Need Manual Ma Manual Manual | Emergency room facility fee (waived if admitted) | \$200 | | \$150 | |
| mmediate attention U Hospital stay | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| Hospital stay | Medical transportation (including emergency and non-emergency) | \$150 | | \$150 | |
| Hospital stay | Jrgent care | \$15 | | \$20 | |
| hospital stay | acility fee (e.g. hospital room) for inpatient stay (including labor and | 10% | | \$250 per day up to | |
| P | delivery, mental health, and substance use) | 10% | | 5 days | |
| | Physician/surgeon fee | 10% | | No charge | |
| | Vental/behavioral health and substance use disorder outpatient office risits | \$15 | | \$20 | |
| | Vental/behavioral health and substance use disorder other outpatient tems and services | \$15 | | \$20 | |
| Pregnancy P | Prenatal care and preconception visits | No charge | | No charge | |
| Н | Home health care (cost share per visit) | 10% | | \$20 | |
| | Dutpatient Rehabilitation and Habilitation services | \$15 | | \$20 | |
| ecovering or | | | | \$150 per day up to | |
| other special S | Skilled nursing care | 10% | | 5 days | |
| ealth needs | Durable medical equipment | 10% | | 10% | |
| Н | Hospice service | No charge | | No charge | |
| Child eye E | Eye exam | No charge | | No charge | |
| aro | I pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| 0 | Dral Exam | | | _ | |
| | Preventive - Cleaning | | | | |
| Child Dental | • | | | | |
| agnostic | Preventive - X-ray | No charge | | No charge | |
| Preventive S | Sealants per Tooth | | | | |
| Т | Copical Fluoride Application | | | | |
| S | Space Maintainers - Fixed | | | | |
| | Restorative Procedures | | | See 2023 2024 | |
| Basic Services P | Periodontal Maintenance Services | 20% | | Dental Copay Schedule | |
| | Crowns and Casts | | | 21130410 | |
| | | | | | |
| Child Dental | Endodontics | | | See 2023 2024 | |
| Major P Services | Periodontics (other than maintenance) | 50% | | Dental Copay Schedule | |
| | Prosthodontics | | | Schedule | |
| C | Dral Surgery | | | | |

Date: June 16, 2022 April 20, 2023 Summary of Benefits and Coverage

| mber oost snaf | e amounts describe the Enrollee's out of pocket costs. | Coinsurance | Plan | Individual-only Copay Pla | |
|--|---|----------------------------------|-----------------------|----------------------------------|------------------|
| tuarial Value - | AV Calculator | 81.9% | | 80.1% <u>81.5</u> | <u>i%</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 | C | \$0 / \$0 / \$ | 0 |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$0 / \$0 / \$0 | C | \$0 / \$0 / \$ | 0 |
| | Individual Out-of-pocket maximum | \$8,550 <u>\$8,7</u> | <u>00</u> | \$8,550 | <u>'00</u> |
| | Family Out-of-pocket maximum | \$17,100 <u>\$17,</u> | <u>400</u> | \$17,100 <u>\$17,</u> | 400 |
| | HSA plan: Self-only coverage deductible | N/A | | N/A | |
| | HSA family plan: Individual deductible | N/A | - | N/A | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deduct Applie |
| | Primary care visit to treat an injury, illness, or condition | \$35 | | \$35 | |
| lealth care provider's office or | Other practitioner office visit | \$35 | | \$35 | |
| linic visit | Specialist visit | \$65 | | \$65 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | | \$40 | | \$40 | |
| | Laboratory Tests | | | | |
| ests | X-rays and Diagnostic Imaging | \$75 | | \$75 | |
| | Imaging (CT/PET scans, MRIs) | 25% | | \$75 | |
| | Tier 1 | \$15 | | \$15 | |
| rugs to | Tier 2 | \$60 | | \$60 | |
| eat illness r condition | Tier 3 | \$85 | | \$85 | |
| | Tier 4 | 20% up to \$250 per script | | 20% up to \$250 per script | |
| | Surgery facility fee (e.g., ASC) | 20% 30% | | \$150 <u>\$130</u> | |
| Outpatient | | 20% 30% | | | |
| ervices | Physician/surgeon fees | | | \$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 | |
| leed mmediate ttention | Medical transportation (including emergency and non-emergency) | \$250 | | \$250 | |
| | Urgent care | \$35 | | \$35 | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 30% | | \$350 \$330 per day | |
| lospital stay | delivery, mental health, and substance use) | | | up to 5 days | |
| | Physician/surgeon fee | 30% | | No charge | |
| lental ealth, ehavioral | Mental/behavioral health and substance use disorder outpatient office visits | \$35 | | \$35 | |
| ealth, or ubstance buse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$35 | | \$35 | |
| regnancy | Prenatal care and preconception visits | No charge | | No charge | |
| | Home health care (cost share per visit) | 20% | | \$30 | |
| lelp | Outpatient Rehabilitation and Habilitation services | \$35 | | \$35 | |
| ecovering or | Skilled nursing care | 30% | | \$150 per day up to | |
| ther special ealth needs | | | | 5 days | |
| | Durable medical equipment | 20% | | 20% | |
| | Hospice service | No charge | | No charge | |
| hild eye | Eye exam | No charge | | No charge | |
| are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | Oral Exam | | | | |
| | Preventive - Cleaning | | | | |
| hild Dental | Preventive - X-ray | | | | |
|)iagnostic nd | | No charge | | No charge | |
| reventive | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| hild Dental Basic | Restorative Procedures | 20% | | See-2023 2024 Dental Copay | |
| asic Services | Periodontal Maintenance Services | 20% | | Schedule | |
| | Crowns and Casts | | | | |
| | Endodontics | | | | |
| Child Dental | | E00/ | | See 2023 2024 | |
| Major Services | Periodontics (other than maintenance) | 50% | | Dental Copay Schedule | |
| | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| Child | Medically necessary orthodontics | 50% | | \$1,000 | |

| ummary of Benefits and Coverage ember Cost Share amounts describe the Enrollee's out of pocket costs. | | Gold | CCSB-only Gold Coinsurance Plan | | CCSB-only Gold Copay Plan | | |
|--|---|----------------------------|---------------------------------------|---|---------------------------------|--|--|
| uarial Value - A | V Calculator | 78.9% | | 80.5% <u>80.7%</u> | | | |
| | Plan design includes a deductible? | Yes, Medical/Pharm | acv | Yes, Medical/Pharn | nacv | | |
| | Integrated Individual deductible | N/A | acy | N/A | nacy | | |
| | 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 Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductik Applies | | |
| | Primary care visit to treat an injury, illness, or condition | \$25 | | \$35 | | | |
| ealth care | Other practitioner office visit | ¢25 | | ¢25 | | | |
| rovider's ffice or | | \$25 | | \$35 | | | |
| linic visit | Specialist visit | \$50 | | \$55 | | | |
| | Preventive care/ screening/ immunization | No charge | | No charge | | | |
| | Laboratory Tests | \$25 | | \$35 | | | |
| ests | X-rays and Diagnostic Imaging | \$65 | | \$55 | | | |
| | Imaging (CT/PET scans, MRIs) | 20% | | \$250 | х | | |
| | | | | | | | |
| | Tier 1 | \$15 | | \$15 | | | |
| rugs to | Tier 2 | \$50 | | \$40 | | | |
| reat illness | Tier 3 | \$00 | | \$70 | | | |
| r condition | ner 5 | \$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 ervices | Physician/surgeon fees | 20% | | \$35 | | | |
| ervices | 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 | X | | |
| | | _ | | _ | | | |
| leed mmediate | Medical transportation (including emergency and non-emergency) | 20% | X | \$250 | Х | | |
| ttention | Urgent care | \$25 | | \$35 | | | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | | | | | | |
| lospital stay | delivery, mental health, and substance use) Physician/surgeon fee | 20% | x | \$600 per day up to 5 days No charge | Х | | |
| Iental | | 2070 | ~ | No charge | | | |
| ealth, ehavioral | Mental/behavioral health and substance use disorder outpatient office visits | \$25 | | \$35 | | | |
| ealth, or ubstance buse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$25 | | \$35 | | | |
| regnancy | Prenatal care and preconception visits | No charge | | No charge | | | |
| | Home health care (cost share per visit) | 20% | | \$30 | | | |
| | Outpatient Rehabilitation and Habilitation services | \$25 | | \$35 | | | |
| lelp ecovering or | | | | | | | |
| ther special | Skilled nursing care | 20% | X | \$300 per day up to 5 days | Х | | |
| ealth needs | Durable medical equipment | 20% | | 20% | | | |
| | Hospice service | No charge | | No charge | | | |
| hild eye | Eye exam | No charge | | No charge | | | |
| are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | | | |
| | Oral Exam | - | | | | | |
| | Preventive - Cleaning | | | | | | |
| hild Dental | - | | | | | | |
| iagnostic nd | Preventive - X-ray | No charge | | No charge | | | |
| reventive | Sealants per Tooth | | | | | | |
| | Topical Fluoride Application | | | | | | |
| | Space Maintainers - Fixed | | | | | | |
| child Dental | Restorative Procedures | 0001 | | See 2023 2024 Dental Copay | | | |
| asic ervices | Periodontal Maintenance Services | 20% | | Schedule | | | |
| | Crowns and Casts | | | | | | |
| | Endodontics | | | | | | |
| hild Dental | | F60 | | See 2023 2024 Dental Copay | | | |
| lajor Services | Periodontics (other than maintenance) | 50% | | Schedule | | | |
| | Prosthodontics | | | | | | |
| | Oral Surgery | | | | | | |
| | | | | | | | |

Summary of Benefits and Coverage

| mber Cost Share | amounts describe the Enrollee's out of pocket costs. | Individual-only Silve | Plan |
|-------------------------------------|---|--|---------------------|
| tuarial Value - A' | V Calculator | 71.6% <u>71.8%</u> | |
| | Plan design includes a deductible? | Yes, Medical/Pharm | acy |
| | Integrated Individual deductible | N/A | uoy |
| | Integrated Family deductible | N/A | |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$4,750 <u>\$5,400</u> / \$85 <u>\$1</u> | <u>50</u> / \$0 |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$9,500 \$10,800 / \$170 \$ | |
| | Individual Out–of–pocket maximum | \$ 8,750 \$9,100 | |
| | Family Out-of-pocket maximum | \$17,500 <u>\$18,200</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 | Deductib Applies |
| | Primary care visit to treat an injury, illness, or condition | \$45 <u>\$50</u> | |
| Health care | Other practitioner office visit | \$45 \$50 | |
| provider's office or | Other practitioner office visit | \$45 | |
| clinic visit | Specialist visit | \$85 | |
| | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | \$50 | |
| Tests | X-rays and Diagnostic Imaging | \$95 | |
| | Imaging (CT/PET scans, MRIs) | \$325 | |
| | | | Pharma |
| | Tier 1 | \$16 | deductik |
| Drugs to | Tier 2 | \$60 | Pharma deductib |
| treat illness | Tier 3 | \$00 | Pharma |
| or condition | | \$90 | deductib |
| | Tier 4 | 20% up to \$250 per script after pharmacy deductible | Pharma deductik |
| Outpatient | Surgery facility fee (e.g., ASC) | 20%- 30% | |
| services | Physician/surgeon fees | 20% 30% | |
| | Outpatient visit | 20% 30% | |
| | Emergency room facility fee (waived if admitted) | \$400 \$450 | |
| | Emergency room physician fee (waived if admitted) | No charge | |
| Need | Medical transportation (including emergency and non-emergency) | \$250 | |
| immediate attention | Urgent care | \$45 | |
| | | | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) | 30% | х |
| Hospital stay | delivery, mental health, and substance use) | | |
| Mental | Physician/surgeon fee | 30% | |
| health, behavioral health, or | Mental/behavioral health and substance use disorder outpatient office visits | \$45 | |
| substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$45 | |
| Pregnancy | Prenatal care and preconception visits | No charge | |
| | Home health care (cost share per visit) | \$45 | |
| Help | Outpatient Rehabilitation and Habilitation services | \$ 45 | |
| recovering or | Skilled nursing care | 30% | x |
| other special health needs | Durable medical equipment | 20% | |
| | | | |
| | | 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 | no onarge | |
| | Topical Fluoride Application | | |
| | Space Maintainers - Fixed | | |
| Child Dental | Restorative Procedures | | |
| Basic Services | Periodontal Maintenance Services | 20% | |
| | Crowns and Casts | | |
| | | | |
| Child Dental | | | |
| Major Services | Periodontics (other than maintenance) | 50% | |
| | Prosthodontics | | |
| | | | |
| | Oral Surgery | | |

| - | nefits and Coverage amounts describe the Enrollee's out of pocket costs. | CCSB-only Silver Coinsurance Plar | 1 | CCSB-only Silver Copay Plan | |
|-----------------------------------|---|---|------------------------|---|-------------------|
| uarial Value - A | V Calculator | 71.9% <u>70.0%</u> | | 71.7% <u>69.7%</u> | |
| | Plan design includes a deductible? | | acv. | Yes, Medical/Pharm | acv |
| | Integrated Individual deductible | N/A | , | N/A | , |
| | Integrated Family deductible | N/A | | N/A | |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$2,500 / \$300 / \$0 | | \$2,500 / \$300 / \$0 |) |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$5,000 / \$600 / \$0 | | \$5,000 / \$600 / \$0 |) |
| | Individual Out-of-pocket maximum | | | \$8,750 | |
| | Family Out-of-pocket maximum | | | \$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 | Deducti Applie |
| | Primary care visit to treat an injury, illness, or condition | \$55 | | \$55 | |
| ealth care | Other prostitioner office visit | 0cc | | ¢ c c | |
| rovider's ffice or | Other practitioner office visit | \$55 | | \$55 | |
| linic visit | Specialist visit | \$90 | | \$90 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests | \$55 | | \$55 | |
| ests | X-rays and Diagnostic Imaging | \$90 | | \$90 | |
| | Imaging (CT/PET scans, MRIs) | 35% | х | \$300 | х |
| | | | ~ | | ~ |
| | Tier 1 | \$20 | | \$19 | |
| rugs to | Tier 2 | \$75 | Pharmacy | \$85 | Pharm |
| eat illness | | | deductible Pharmacy | | deducti Pharm |
| r condition | Tier 3 | \$105 | deductible | \$110 | deducti |
| | Tier 4 | 30% up to \$250 per script after pharmacy deductible | Pharmacy deductible | 30% up to \$250 per script after pharmacy deductible | Pharm deducti |
| | Surgery facility fee (e.g., ASC) | 35% | х | 35% | Х |
| utpatient | Physician/surgeon fees | 35% | | 30% 35% | |
| ervices | Outpatient visit | 35% | | 30% 35% | |
| | | | V | 30% 35% | V |
| | Emergency room facility fee (waived if admitted) | 35% | Х | | Х |
| Need immediate | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| | Medical transportation (including emergency and non-emergency) | 35% | Х | 30% 35% | х |
| ttention | Urgent care | \$55 | | \$55 | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 05% | X | 40% 35% | X |
| lospital stay | delivery, mental health, and substance use) Physician/surgeon fee | 35% | x x | 4 0% 35% | Х |
| lental ealth, ehavioral | Mental/behavioral health and substance use disorder outpatient office visits | \$55 | | \$55 | |
| ealth, or ubstance | Mental/behavioral health and substance use disorder other outpatient items and services | \$55 | | \$55 | |
| buse needs regnancy | Prenatal care and preconception visits | No charge | | No charge | |
| - sg.runoy | | | | | |
| | Home health care (cost share per visit) | 35% | | \$45 | |
| elp | Outpatient Rehabilitation and Habilitation services | \$55 | | \$55 | |
| ecovering or ther special | Skilled nursing care | 35% | х | 40%- 35% | х |
| ealth needs | Durable medical equipment | 35% | | 40% 35% | |
| | Hospice service | No charge | | No charge | |
| hild out | Eye exam | No charge | | No charge | |
| hild eye are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | _ | | No charge | |
| | | No charge | | no charge | |
| | Oral Exam | | | | |
| hild Dental | Preventive - Cleaning | | | | |
| iagnostic | Preventive - X-ray | No charge | | No charge | |
| nd reventive | Sealants per Tooth | . to shargo | | . to sharge | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| hild Dental | Restorative Procedures | | | | |
| asic | | 20% | | See 2023 2024 Dental Copay Schedule | |
| ervices | Periodontal Maintenance Services | | | | |
| | Crowns and Casts | | | | |
| | Endodontics | | | | |
| Child Dental | | | | See-2023 2024 Dental Copay | |
| lajor | Periodontics (other than maintenance) | 50% | | Schedule | |
| child Dental Najor Services | Periodontics (other than maintenance) Prosthodontics | 50% | | Schedule | |
| lajor | | 50% | | Schedule | |

Oral Surgery

Medically necessary orthodontics

50%

Child Orthodo

ntics

| - | nefits and Coverage amounts describe the Enrollee's out of pocket costs. | CCSB-o Silve HDHP P | r |
|---------------------------------|---|-----------------------------------|-------------------|
| tuarial Value - A | V Calculator | 71.7% | , D |
| | Plan design includes a deductible? | Yes, integ | |
| | Integrated Individual deductible | \$2,700 <u>\$2,850</u> | integrated |
| | Integrated Family deductible | \$5,400 | integrated |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | N/A | |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | N/A | |
| | Individual Out–of–pocket maximum | \$7,200 | |
| | Family Out-of-pocket maximum | \$14,400 <u>\$1</u> | |
| | HSA plan: Self-only coverage deductible HSA family plan: Individual deductible | \$2,700 | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applie |
| Lvein | Primary care visit to treat an injury, illness, or condition | 25% | x |
| Health care provider's | Other practitioner office visit | 25% | x |
| office or clinic visit | Specialist visit | 25% | x |
| | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | 25% | х |
| Tests | X-rays and Diagnostic Imaging | 25% | x |
| | Imaging (CT/PET scans, MRIs) | 25% | x |
| | | 25% up to \$250 per | |
| | Tier 1 | script | X |
| Drugs to | Tier 2 | 25% up to \$250 per script | х |
| treat illness or condition | Tier 3 | 25% up to \$250 per | x |
| | Tier 4 | script 25% up to \$250 per | x |
| _ | Surgery (apility for (a.g. ASC) | script | V |
| Outpatient | Surgery facility fee (e.g., ASC) | 25% | X |
| services | Physician/surgeon fees | 25% | X |
| | Outpatient visit | 25% | X |
| | Emergency room facility fee (waived if admitted) | 25% | Х |
| | Emergency room physician fee (waived if admitted) | 0% | X |
| Need immediate attention | Medical transportation (including emergency and non-emergency) | 25% | X |
| | Urgent care | 25% | x |
| Hospital stay | Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) | 25% | x |
| | Physician/surgeon fee | 25% | x |
| Mental health, behavioral | Mental/behavioral health and substance use disorder outpatient office visits | 25% | х |
| health, or substance | Mental/behavioral health and substance use disorder other outpatient items and services | 25% | x |
| abuse needs | | | |
| Pregnancy | Prenatal care and preconception visits | No charge | |
| | Home health care (cost share per visit) | 25% | X |
| Help recovering or | Outpatient Rehabilitation and Habilitation services | 25% | X |
| other special | Skilled nursing care | 25% | X |
| health needs | Durable medical equipment | 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 | | |
| Child Dent- | Preventive - Cleaning | | |
| Child Dental Diagnostic | Preventive - X-ray | No charge | |
| and Preventive | Sealants per Tooth | No ondruge | |
| | Topical Fluoride Application | | |
| | Space Maintainers - Fixed | | |
| Child Dental | Restorative Procedures | 2004 | |
| Basic Services | Periodontal Maintenance Services | 20% | |
| | Crowns and Casts | | |
| 01.11.1-5 | Endodontics | | |
| Child Dental Major | Periodontics (other than maintenance) | 50% | |
| Services | | | 1 |

Date: June 16, 2022 April 20, 2023

| mber Cost Share | amounts describe the Enrollee's out of pocket costs. | Silver P 100%-150% | | Silver Plan 150%-200% FPl | L |
|--------------------------------------|---|--------------------------------------|-----------------------|---|---------------------|
| | | | | | |
| uarial Value - A' | | 94.9% | | 87.9% | |
| | Plan design includes a deductible? | Yes, Medical/F | harmacy | Yes, Medical/Pharm | nacy |
| | Integrated Individual deductible | N/A | | N/A | |
| | Integrated Family deductible | N/A | / \$0 | N/A | to |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$75 / \$0 \$150 / \$0 | | \$800 / \$25 <u>\$50</u> / \$ | |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | | | \$1,600 / \$50 <u>\$100</u> , | 7 \$0 |
| | Individual Out–of–pocket maximum | \$900 <u>\$1,</u> | | \$3,000 <u>\$3,150</u> | |
| | Family Out-of-pocket maximum HSA plan: Self-only coverage deductible | \$1,800 <u>\$2</u> N/A | | \$ 6,000 <u>\$6,300</u> N/A | |
| | HSA family plan: Individual deductible | | | N/A | |
| Common Medical | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductib Applies |
| Event | Primary care visit to treat an injury, illness, or condition | \$5 | | \$15 | |
| Health care provider's | Other practitioner office visit | \$5 | | \$15 | |
| office or | | <i>Q</i> | | \$10 | |
| linic visit | Specialist visit | \$8 | | \$25 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests | \$8 | | \$20 | |
| ests | X-rays and Diagnostic Imaging | \$8 | | \$40 | |
| | Imaging (CT/PET scans, MRIs) | \$50 | | \$100 | |
| | Tier 1 | \$3 | | \$5 \$6 | Pharma |
| | | ψυ | | ψο ψο | deductil |
| Drugs to | Tier 2 | \$10 | | \$25 | Pharma deductil |
| reat illness or condition | Tier 3 | \$15 | | \$45 | Pharma |
| | | | | ψτο | deductil |
| | Tier 4 | 10% up to \$150 per script | | 15% up to \$150 per script | Pharma deductil |
| | Surgery facility fee (e.g., ASC) | 10% | | 15% 20% | |
| Outpatient | Physician/surgeon fees | 10% | | 15% 20% | |
| ervices | Outpatient visit | 10% | | 15% 20% | |
| | Emergency room facility fee (waived if admitted) | \$50 | | \$150 | |
| | | | | | |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| Need immediate attention | Medical transportation (including emergency and non-emergency) | \$30 | | \$75 | |
| | Urgent care | \$5 | | \$15 | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 10% | х | 25% 20% | x |
| lospital stay | delivery, mental health, and substance use) Physician/surgeon fee | 10% | | 25% 20% | |
| Mental nealth, | Mental/behavioral health and substance use disorder outpatient office | \$5 | | \$15 | |
| behavioral | visits | φυ | | φισ | |
| ealth, or substance buse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$5 | | \$15 | |
| regnancy | Prenatal care and preconception visits | No charge | | No charge | |
| | Home health care (cost share per visit) | \$3 | | \$15 | |
| lein | Outpatient Rehabilitation and Habilitation services | \$5 | | \$15 | |
| lelp ecovering or | | | х | 25% 20% | x |
| ther special ealth needs | Skilled nursing care | 10% | ٨ | | X |
| | Durable medical equipment | 10% | | 15% | |
| | Hospice service | No charge | | No charge | |
| hild eye | Eye exam | No charge | | No charge | |
| are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | Oral Exam | | | | |
| | Preventive - Cleaning | | | | |
| hild Dental | Preventive - X-ray | | | | |
|)iagnostic nd | Sealants per Tooth | No charge | | No charge | |
| Preventive | Topical Fluoride Application | | | | |
| | | | | | |
| | Space Maintainers - Fixed | | | | |
| child Dental Basic | Restorative Procedures | 20% | | 20% | |
| Services | Periodontal Maintenance Services | | | | |
| | Crowns and Casts | | | | |
| bild Dentel | Endodontics | | | | |
| Child Dental Najor | Periodontics (other than maintenance) | 50% | | 50% | |
| Services | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| | | | | | 1 |

Summary of Benefits and Coverage

Child Orthodontics

Medically necessary orthodontics

| mber Cost Share | amounts describe the Enrollee's out of pocket costs. | Silver Plan 200%-250% FPL | |
|--|---|---|-----------------------|
| tuarial Value - A | V Calculator | 73.9% | |
| | Plan design includes a deductible? | Yes, Medical/Pharm | асу |
| | Integrated Individual deductible | N/A | |
| | Integrated Family deductible | N/A | |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$4,750 <u>\$5,400</u> / \$30 <u>\$1</u> | <mark>50</mark> / \$0 |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$ 9,500 <u>\$10,800</u> / \$60 <u>\$</u> | |
| | Individual Out-of-pocket maximum | | , 40 |
| | | \$7,250 <u>\$7,550</u> | |
| | Family Out-of-pocket maximum | \$14,500 <u>\$15,100</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 | Deductib Applies |
| Event | Primary care visit to treat an injury, illness, or condition | \$45 <u>\$50</u> | , the second |
| lealth care provider's | Other practitioner office visit | \$45 <u>\$50</u> | |
| office or clinic visit | | # 05 # 00 | |
| clinic visit | Specialist visit | \$85 | |
| | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | \$50 | |
| Tests | X-rays and Diagnostic Imaging | \$90 | |
| | Imaging (CT/PET scans, MRIs) | \$325 | |
| | | ψυζυ | Phore |
| | Tier 1 | \$16 \$19 | Pharma deductik |
| | Tier 2 | \$55 | Pharma |
| Drugs to reat illness | | φυσ | deductib |
| or condition | Tier 3 | \$85 | Pharma deductib |
| | Tier 4 | 20% up to \$250 per script after pharmacy deductible | Pharma |
| | Surgery facility fee (e.g., ASC) | 20% 30% | deddciic |
| Dutpatient | Physician/surgeon fees | 20% 30% | |
| services | | | |
| | Outpatient visit | 20% 30% | |
| | Emergency room facility fee (waived if admitted) | \$400 \$450 | |
| | Emergency room physician fee (waived if admitted) | No charge | |
| Need | Medical transportation (including emergency and non-emergency) | \$250 | |
| mmediate attention | Urgent care | \$45 <u>\$50</u> | |
| Hospital stay | Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee | 30% 30% | х |
| Mental nealth, | Mental/behavioral health and substance use disorder outpatient office visits | \$45 | |
| behavioral nealth, or substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$45 | |
| _ | Prenatal care and preconception visite | Noak | |
| Pregnancy | Prenatal care and preconception visits | No charge | |
| | Home health care (cost share per visit) | \$40 | |
| lelp | Outpatient Rehabilitation and Habilitation services | \$45 <u>\$50</u> | |
| ecovering or | Skilled nursing care | 30% | х |
| other special nealth needs | - | | ~ |
| | Durable medical equipment | 20% | |
| | Hospice service | No charge | |
| Child eye | Eye exam | No charge | |
| care | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | |
| | Oral Exam | Ŭ | |
| | | | |
| Child Dental | Preventive - Cleaning | | |
| Diagnostic | Preventive - X-ray | No chorgo | |
| and Preventive | Sealants per Tooth | No charge | |
| eventive | Topical Fluoride Application | | |
| | | | |
| | Space Maintainers - Fixed | | |
| Child Dental Basic | Restorative Procedures | 20% | |
| Services | Periodontal Maintenance Services | 2070 | |
| | Crowns and Casts | | |
| | Endodontics | | |
| Child Dental | | | |
| Major Services | Periodontics (other than maintenance) | 50% | |
| | Prosthodontics | | |
| | Oral Surgery | | |
| | | | |

50%

Date: June 16, 2022 April 20, 2023 Summary of Benefits and Coverage

| Name Control Control <thcontrol< th=""> <thcontrol< th=""> <thcont< th=""><th>ber Cost Share a</th><th>amounts describe the Enrollee's out of pocket costs.</th><th>Bronze Plan</th><th></th><th>Bronze HDHP Pla</th><th>n</th></thcont<></thcontrol<></thcontrol<> | ber Cost Share a | amounts describe the Enrollee's out of pocket costs. | Bronze Plan | | Bronze HDHP Pla | n | |
|---|--|---|------------------------|----------------------|--------------------------|------------------|--|
| UniversiteUniversiteUniversiteUniversiteUniversite19991 | uarial Value - A\ | V Calculator | 64.7% 64.4% | | 64.2% 64 9 | <u>%</u> | |
| Independencial and sectorsIndependencial and sectorsPrior 2000 (1990) (19 | | | | nacy | | | |
| <th c<="" td=""><td></td><td>-</td><td></td><td>,</td><td>_</td><td></td></th> | <td></td> <td>-</td> <td></td> <td>,</td> <td>_</td> <td></td> | | - | | , | _ | |
| Inded 400 migrad mig | | - | | | | • | |
| <table-container>Image show the strain of th</table-container> | | | | \$0 | | J | |
| Interfact of a control of a contro control of a | | | \$12,600 / \$1,000 | / \$0 | N/A | | |
| The Subset Subset of part or subset of the Subset of part of Pa | | | | | \$7,000 \$7,0 | 50 | |
| Singlist Single operations of the sector o | | | | | | | |
| Utation (bit (bit (bit (bit (bit (bit (bit (bit | | | N/A | | \$7,000 \$7,0 | 50 | |
| Induction Induction <t< td=""><td></td><td>HSA family plan: Individual deductible</td><td>N/A</td><td></td><td>\$7,000 \$7,0</td><td>50</td></t<> | | HSA family plan: Individual deductible | N/A | | \$7,000 \$7,0 | 50 | |
| Phase can what is used as is used base as is u | ledical | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deduct Applie | |
| Other participant offer sizkOther participant offer sizk <td></td> <td>Primary care visit to treat an injury, illness, or condition</td> <td>\$65</td> <td></td> <td>0%</td> <td>х</td> | | Primary care visit to treat an injury, illness, or condition | \$65 | | 0% | х | |
| The order Protects and surveySecond viaiOne of the order Protects and surveyOne of the order | | Other practitioner office visit | \$65 \$60 | | 0% | x | |
| Initial of additional of additional productsInitial of additional products <thinitial additional="" of="" produc<="" td=""><td>ffice or</td><td></td><td></td><td>· ·</td><td></td><td></td></thinitial> | ffice or | | | · · | | | |
| Laboratory TestsLaboratory TestsMark Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Imaging Test 1Mark Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Imaging Test 2Mark Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Imaging Arups and Dogrands: Arups and Dogrand: Aru | linic visit | Specialist visit | \$95 | | 0% | Х | |
| ReferX-fag and Diagnosite langung (Insign) CUPET sons, MRI9)X du/sX du/s <t< td=""><td></td><td>Preventive care/ screening/ immunization</td><td>No charge</td><td></td><td>No charge</td><td></td></t<> | | Preventive care/ screening/ immunization | No charge | | No charge | | |
| Image (CTPCT scame, NRIN)449.00X99.0000.0000Ter 1Ter 21000000000000000000000000000000000000 | | Laboratory Tests | \$40 | | 0% | х | |
| Trian Sensitive and integer the sensitive sens | ests | X-rays and Diagnostic Imaging | 40% | х | 0% | х | |
| Tri 1 Selection of the selection o | | Imaging (CT/PET scans, MRIs) | 40% | х | 0% | x | |
| Thrs 2 Thrs 3 Thrs 4 Thrs 4< | | | | | | | |
| Instantion Instantion <thinstantinstantion< th=""> Instantion <thin< td=""><td></td><td></td><td></td><td></td><td>U%</td><td>X</td></thin<></thinstantinstantion<> | | | | | U% | X | |
| Strain Bin Prime Strain Stra | orugs to | Tier 2 | | | 0% | x | |
| Centre Inite - 2 Defaultancy dedactifie Defaultancy defaultancy dedactifie Defaultancy defaultancy defaultancy defaultancy defaultancy defaultancy defaultancy defaultancy defaul | reat illness | Tior 2 | | | 001 | | |
| Initia patername planname | condition | | | | U% | X | |
| Surgety facility fee (a.g., ASC) 40% X 0% X Physicality arguing fees 40% X 0% X Outpatent visit 40% X 0% X Outpatent visit 40% X 0% X Outpatent visit 40% X 0% X Energency room physical fee (waiwed if admitted) No charge 0% X 0% X Outpatent visit facility fee (a.g., taspited room (for inpatient stay (rologing labor and divide) 40% X 0% X Object and services facility fee (a.g., taspited room (for inpatient stay (rologing labor and divide) 40% X 0% X Outpatent visit facility fee (a.g., taspited room (for inpatient stay (rologing labor and divide) 40% X 0% X Outpatent visit facility fee (a.g., taspited room (for inpatient stay (rologing to and divide) 40% X 0% X Outpatent visit facility fee (a.g., taspited room (for inpatient stay (rologing to and divide) A0% X 0% X Outp | | Tier 4 | | | 0% | x | |
| Physical bargeon fees Adia X Original X Original X Energency room plashin fee (valved # damitted) Adia Adia X < | _ | | | | 00/ | v | |
| implication using contrasts implicatin contrasts impli | utpatient | | | | | | |
| Emergency room facility fee (valved if admitted) 40% X 0% X Emergency room physician fee (valved if admitted) No charge 47% X 0% X Intergency room physician fee (valved if admitted) No charge 47% X 0% X Intergency room physician fee (valved if admitted) No charge 47% X 0% X Intergency room physician fee (valved if admitted) After 1st three orop-percentive valis 0% X Intergency metal result, and substance use disorder outpatient 40% X 0% X Interalt/the/word results and substance use disorder outpatient 6865 580 X 0% X Interalt/the/word results and substance use disorder outpatient 6865 580 X 0% X Interalt charing and preconception visits No charge X 0% X Interalt charing and preconception visits No charge 0% X 0% X Interal therain/therace service 3865 560 No charge 0% X 0% X Intergenc | | Physician/surgeon fees | 40% | X | 0% | X | |
| Bergenery comprises in the (waived if admitted) No charge 0% X Wedded transportation (including emergency and non-emergency) 40% X 0% X Optimizer Comprises in the (waived if admitted) Macro transportation (including emergency and non-emergency) 40% X 0% X Optimizer Comprises in the (waived if admitted) Macro transportation (including emergency and non-emergency) 40% X 0% X Optimizer Comprises in the determiner | | Outpatient visit | 40% | х | 0% | Х | |
| end Mode/all transportation (including emergency and non-emergency) Mark X 0% X upper lemmediate transmission Quark transportation (including emergency and non-emergency) 40% X 0% X upper lemmediate transmission Gelliny (or (o.g. hospital noom) for inputions stay (including labor and physician/surgenci tec sectors) 40% X 0% X emeral asting transmission Physician/surgenci tec visits Meral/behavioral health and substance use disorder outpatient visits Sectors 000 After 15 three non- preventive visits 0% X emeral asting transmission Meral/behavioral health and substance use disorder outpatient visits Sectors 000 X 0% X regreent Pensata care and preconception visits 0% X 0% X ability care Meral/behavioral health and substance use disorder outpatient visits Sectors 0% X 0% X termediate area preconception visits 0% Ad0% X 0% X termediate preconception visits 0% 0% No No No No No No <td></td> <td>Emergency room facility fee (waived if admitted)</td> <td>40%</td> <td>x</td> <td>0%</td> <td>Х</td> | | Emergency room facility fee (waived if admitted) | 40% | x | 0% | Х | |
| hind calible for the first of | | Emergency room physician fee (waived if admitted) | No charge | | 0% | х | |
| titution Series of the | leed | Medical transportation (including emergency and non-emergency) | 40% | x | 0% | x | |
| Origin tab Origin | | | | After 1st three non- | | | |
| Idelicity, mental health, and substance use) Idelicity, mental health, and substance use of sord or updatent office iteratube havioral health and substance use disorder outpatient office iteratube havioral health and substance use disorder outpatient office iteratube havioral health and substance use disorder outpatient office buse needs See Sa0 After 1st Iteratube preventive visits Op/so X regence of buse needs Mental behavioral health and substance use disorder outpatient office buse needs See Sa0 After 1st Iterators preventive visits Op/so X regence of buse needs Mental health and substance use disorder outpatient form a services Op/so X Op/so X regence of buse needs Mental health and substance use disorder outpatient form a services Mental health and substance use disorder outpatient form a services Mental health and substance use disorder outpatient form a services No charge X Op/so X regence of the special active form and Habilitation and Habilitation services Mo/so X Op/so X reade and preconception visits Mo/so X Op/so X X use of patient Rehabilitation and Habilitation services Mo/so X Op/so X theap Sec san No charge< | | Urgent care | \$02 | preventive visits | 0% | X | |
| Identify in matrix hard substance use disorder outpatient office sists Add% X 0% X Instance intervision issues and services Physicina/surgeon fee 40% X 0% X Instance intervision issues and services Restal/behavioral health and substance use disorder outpatient issues and services Seis 522 X 0% X Instance issues and services General care and preconception visits No charge X 0% X Instance (cost share per visit) Oko charge 40% X 0% X Outpatient Rehabilitation and Health and substance issues and services 0% 40% X 0% X Outpatient Rehabilitation and Health and substance issues and care (cost share per visit) 0% 0% X 0% X Outpatient Rehabilitation and Health and substance issues and care (cost share per visit) 0% 0% X 0% X Outpatient Rehabilitation and Health and substance issues and care (cost share per visit) 0% 0% X 0% X Intervisit Seiner visit No charge No charge No charge< | | | 40% | x | 0% | х | |
| Initial setti, setti assistance use disorder outpatient office visits After 1st three nor preventive visits 0% X Menial/behavioral health and substance use disorder outpatient office visits Set 520 X 0% X Menial/behavioral health and substance use disorder other outpatient office visits Set 520 X 0% X Menial/behavioral health and substance use disorder other outpatient means and services No charge X 0% X Menial/behavioral health and substance use disorder other outpatient forms and services No charge X 0% X Menial/behavioral health and substance use disorder other outpatient forms and services No charge X 0% X Menial/behavioral health and substance use disorder outpatient forms and services No charge X 0% X Menial/behavioral health and substance use disorder outpatient forms and services Stilled nursing care No charge X 0% X Outpatient Rehabilitation and Habilitation services No charge | lospital stay | | | | | | |
| earth, visits methational substance use disorder other outpatient terms and services 0% X regnancy Prenatal care and preconception visits No charge | Iontal | | 40 % | | 0 % | ^ | |
| Merital behavioral health and substance use disorder other outpatient buses needs See 550 X 0% X regnancy Prenatal care and preconception visits No charge No charge No charge No charge Home health care (cost share per visit) 40% X 0% X Outpatient Rehabilitation and Habilitation services 566 550 0 0 X Duable medical equipment 40% X 0% X home health care (cost share per visit) 00 charge 00 X 0% X Duable medical equipment 40% X 0% X 0% X hair of glasses per year (or contact lenses in lieu of glasses) No charge No c | ealth, ehavioral | | \$65 | | 0% | х | |
| Home health care (cost share per visit) 40% X 0% X Outpatient Rehabilitation and Habilitation services \$65 560 0% X Skilled nursing care 40% X 0% X Durable medical equipment 40% X 0% X Hone health care (cost share per visit) 00 X 0% X Durable medical equipment 40% X 0% X Hone jee service No charge 0% X 0% X Proventive - Cleaning No charge No charge </td <td>ubstance</td> <td></td> <td>\$65</td> <td>×</td> <td>0%</td> <td>х</td> | ubstance | | \$65 | × | 0% | х | |
| Bige optime and the babilitation and Habilitation services \$65 \$60 0 0% X Skilled nursing care 40% X 0% X Durable medical equipment 40% X 0% X Haid optime medical equipment 0% X 0% X Haid optime medical equipment 0% X 0% X Haid optime medical equipment No charge No charge 0% X Haid optime medical equipment No charge No charge No charge 0% X Init of glasses per year (or contact lenses in lieu of glasses) No charge | regnancy | Prenatal care and preconception visits | No charge | | No charge | | |
| Bigs of the shabilitation and Habilitation services \$65 \$60 0 0% X Skiled nursing care 40% X 0% X Durabe medical equipment 40% X 0% X Hold op 10% 10% X 0% X Hold op 10% 10% 10% X 0% X Hold op 10% 1 | | Home health care (cost share per visit) | - | x | | х | |
| Skilled nursing care Skilled nursing care 0% X Durable medical equipment 40% X 0% X Hold eye No charge 0% X File exam No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Oral Exam Oral Exam No charge No charge No charge Preventive - Cleaning No charge No charge No charge Preventive - Cleaning No charge No charge No charge Preventive - Strady Strady Procedures No charge No charge No charge Preventive - Fixed Preventive - Strady Preventive - Strady Strady Procedures Strady Procedures Priodontial Maintenance Services Preventive - Strady Preventive - Strady Preventive - Strady Strady Procedures Findodontics Preventive - Strady Preventive - Strady Preventive - Strady Preventive - Strady Findodontics Preventive - Strady Strady Procedures Strady Procedures Strady Procedures Findodontics Preventive - Strady Strady Procedures Strady Procedures Strady Procedures Preventive - Strady Procedures Prev | | | | | | | |
| there special cattly needs Skilled nursing care Ad% X 0% X Durable medical equipment 40% X 0% X Hospice service No charge 0% X File exam No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Preventive - Cleaning No charge No charge No charge Preventive - Cleaning No charge No charge No charge Preventive - Cleaning No charge No charge No charge Preventive - Cleaning Preventive - Cleaning No charge No charge Preventive - Cleaning Preventive - Strad Ad% Ad% Sealants per Tooth Sealants per Tooth Ad% Ad% Space Maintainers - Fixed Ad% Ad% Ad% Preventive - Strad Acord Acord Acord Freidodntal Maintenance Services Acord Acord Acord Freidodntics Freidodntics Stoward Casts Stoward Protodntics (other than maintenance) Stoward Stoward Stoward Protodntics Ordsources Stoward Stoward Stoward N | | | | | | | |
| Induce medical equipment 10% X 0% X Hospice service 00 charge 00 charge 0% X Shide eye are 1 pair of glasses per year (or contact lenses in lieu of glasses) 00 charge | ther special | Skilled nursing care | 40% | X | 0% | X | |
| Initial eye are Eye cam No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Oral Exam Preventive - Cleaning Pr | earm needs | Durable medical equipment | 40% | x | 0% | х | |
| Inderge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Preventive - X- | | Hospice service | No charge | | 0% | х | |
| are 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Freventive - Cleaning Freventive - Cleaning Freventive - Cleaning Freventive - Stappen | hild eye | Eye exam | No charge | | No charge | | |
| Oral ExamOral ExamPreventive - CleaningPreventive - C | | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | | |
| Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Pre | | | | | | | |
| Inide Density ingonspective revertive Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed No charge No c | | | | | | | |
| No charge No charge No charge Sealants per Tooth Topical Fluoride Application No charge No charge Topical Fluoride Application Space Maintainers - Fixed No charge No charge Main Composition Restorative Procedures 20% 20% 20% Periodontal Maintenance Services Crowns and Casts 20% 20% 20% Endodontics Feriodontics (other than maintenance) 50% 50% 50% 50% Prosthodontics Oral Surgery Oral Surgery Songery Songery Songery Songery Songery | | - | | | | | |
| reventive Facility per routh | | | No charge | | No charge | | |
| Space Maintainers - Fixed Image: Constraint of the second sec | | | | | | | |
| hid Dental services Restorative Procedures 20% 20% 20% Periodontal Maintenance Services 20% | | Topical Fluoride Application | | | | | |
| Assic ervices 20% 20% Periodontal Maintenance Services 20% 20% Crowns and Casts Findodontics Findodontics Endodontics Periodontics (other than maintenance) 50% Posthodontics Fosthodontics 50% Prosthodontics Oral Surgery 50% | | Space Maintainers - Fixed | | | | | |
| Periodontal Maintenance Services Periodontal Maintenance Services Image: Comparison of the service of the serv | Child Dental | Restorative Procedures | 0001 | | 0001 | | |
| Image: A period on tics Frid odontics 50% 50% 50% 50% 50% Image: A period on tics Frosthod on tics 50% | | Periodontal Maintenance Services | 20% | | 20% | | |
| Image: Shild Dental Bajor Endodontics Periodontics (other than maintenance) 50% Prosthodontics Forsthodontics Oral Surgery Oral Surgery | | | | | | | |
| Child Dental lajor services Periodontics (other than maintenance) 50% 50% Prosthodontics Oral Surgery 0 1 | | | | | | | |
| Prosthodontics Oral Surgery | | | | | FOR | | |
| Oral Surgery | | | 50% | | 50% | | |
| | | | | | | | |
| | | Oral Surgery | | | | | |

Date: June 16, 2022 April 20, 2023

| tuarial Value - | | | |
|--|---|---------------------|---|
| | Plan design includes a deductible? | | integrated |
| | Integrated Individual deductible | | 9.450 integrated |
| | Integrated Family deductible | \$18,200 | 18,900 integrated |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | | N/A |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | 6 0 (| N/A |
| | Individual Out–of–pocket maximum | | 00 |
| | Family Out-of-pocket maximum | \$18,2 | 900 <u>\$18,900</u> |
| | HSA plan: Self-only coverage deductible HSA family plan: Individual deductible | | N/A N/A |
| Common Medical | Service Type | Member Cost | Deductible Applie |
| Event | Primary care visit to treat an injury, illness, or condition | Share 0% | After 1st three no |
| Health care | | | preventive visits After 1st three no |
| provider's office or | Other practitioner office visit | 0% | preventive visits |
| clinic visit | Specialist visit | 0% | x |
| | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | 0% | х |
| Tests | X-rays and Diagnostic Imaging | 0% | x |
| 10010 | | | |
| | Imaging (CT/PET scans, MRIs) | 0% | Х |
| | Tier 1 | 0% | х |
| | Tier 2 | 0% | x |
| Drugs to treat illness | | 0% | ^ |
| or condition | Tier 3 | 0% | х |
| | Tier 4 | 0% | x |
| | | 070 | ~ |
| Outpotiont | Surgery facility fee (e.g., ASC) | 0% | Х |
| Outpatient services | Physician/surgeon fees | 0% | х |
| | Outpatient visit | 0% | x |
| | Emergency room facility fee (waived if admitted) | 0% | х |
| | Emergency room physician fee (waived if admitted) | No charge | |
| Need | Medical transportation (including emergency and non-emergency) | 0% | x |
| immediate | | 070 | |
| attention | Urgent care | 0% | After 1st three no preventive visits |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | | |
| Hospital stay | delivery, mental health, and substance use) | 0% | Х |
| | Physician/surgeon fee | 0% | х |
| Mental health, behavioral | Mental/behavioral health and substance use disorder outpatient office visits | 0% | After 1st three no preventive visits |
| health, or substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | 0% | x |
| Pregnancy | Prenatal care and preconception visits | No charge | |
| | Home health care (cost share per visit) | 0% | Х |
| | | | |
| Help recovering or | Outpatient Rehabilitation and Habilitation services | 0% | X |
| 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 | f glasses per year (or contact lenses in lieu of glasses) | 0% | x |
| | Oral Exam | 070 | ~ |
| | | | |
| Child Dental | Preventive - Cleaning | | |
| Diagnostic | Preventive - X-ray | No charge | |
| and Preventive | Sealants per Tooth | | |
| | Topical Fluoride Application | | |
| | Space Maintainers - Fixed | | |
| Child Dental | Restorative Procedures | | |
| Basic Services | Periodontal Maintenance Services | 0% | X |
| | Crowns and Casts | | |
| | Endodontics | | |
| Child Dental | | 001 | |
| Major Services | Periodontics (other than maintenance) | 0% | Х |
| | Prosthodontics | | |
| | Oral Surgery | | |
| Child | Medically necessary orthodontics | 0% | x |

Date: June 16, 2022 April 20, 2023

Child Orthodontics Medically necessary orthodontics



| | , 2022 <u>April 20, 2023</u> | | CALIFC M | RNIA | |
|-------------------------------------|--|----------------------------------|-----------------------|--------------------------------|-------------------|
| - | nefits and Coverage amounts describe the Enrollee's out of pocket costs. | Individual-only F Coinsurance | Platinum | Individual-only F Copay Pla | |
| tuarial Value - A | V Calculator | 91.8% <u>91.9</u> | 1% | 89.8% <u>90.7</u> | % |
| tuariai value - A | | No | <u>178</u> | No | <u>70</u> |
| | Plan design includes a deductible? | \$0 | | \$0 | |
| | Integrated Individual deductible | | | | |
| | 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 |
| | Individual Out–of–pocket maximum | \$4,500 | | \$4,500 | |
| | Family Out-of-pocket maximum | \$9,000 | | \$9,000 | |
| | HSA plan: Self-only coverage deductible | N/A | | N/A | |
| | HSA family plan: Individual deductible | N/A | | N/A | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deducti Applie |
| | Primary care visit to treat an injury, illness, or condition | \$15 | | \$15 | |
| Health care | | 045 | | 01 5 | |
| provider's | Other practitioner office visit | \$15 | | \$15 | |
| clinic visit | Specialist visit | \$30 | | \$30 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | • | - | | | |
| | Laboratory Tests | \$15 | | \$15 | |
| ests | X-rays and Diagnostic Imaging | \$30 | | \$30 | |
| | Imaging (CT/PET scans, MRIs) | 10% | | \$75 | |
| | Tier 1 | \$5 \$7 | | \$5 \$7 | |
| Drugs to | Tier 2 | \$15 \$16 | | \$15 \$16 | |
| reat illness or condition | Tier 3 | \$25 | | \$25 | |
| | Tier 4 | 10% up to \$250 per | | 10% up to \$250 per | |
| _ | | script | | script | |
| Dutpatient | Surgery facility fee (e.g., ASC) | 10% | | \$100 \$75 | |
| ervices | 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 | |
| leed mmediate attention | Medical transportation (including emergency and non-emergency) | \$150 | | \$150 | |
| | Urgent care | \$15 | | \$15 | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 10% | | \$250 \$225 per day | |
| lospital stay | delivery, mental health, and substance use) | | | up to 5 days | |
| Mental | Physician/surgeon fee | 10% | | No charge | |
| nealth, behavioral nealth, or | Mental/behavioral health and substance use disorder outpatient office visits | \$15 | | \$15 | |
| substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$15 | | \$15 | |
| Pregnancy | Prenatal care and preconception visits | No charge | | No charge | |
| | Home health care (cost share per visit) | 10% | | \$20 | |
| loln | Outpatient Rehabilitation and Habilitation services | \$15 | | \$15 | |
| lelp ecovering or | | | | \$15 \$150 \$125 per day | |
| other special | Skilled nursing care | 10% | | up to 5 days | |
| ealth needs | Durable medical equipment | 10% | | 10% | |
| | Hospice service | No charge | | No charge | |
| Shild cure | Eye exam | No charge | | No charge | |
| Child eye are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | Oral Exam | | | | |
| | Preventive - Cleaning | | | | |
| Child Dental Diagnostic | - | | | | |
| | Preventive - X-ray | Not Covered | | Not Covered | |
| nd Preventive | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| Child Dents | Space Maintainers - Fixed | | | | |
| Child Dental Basic | Restorative Procedures | 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 | | | | |
| Child | | | | | |

Not Covered

Not Covered

Endodontics

Prosthodontics Oral Surgery

Periodontics (other than maintenance)

Medically necessary orthodontics

Child Dental Major Services

Child Orthodontics

| - | nefits and Coverage amounts describe the Enrollee's out of pocket costs. | CCSB-on Platinum Coinsurance | i i | CCSB-on Platinum Copay Pla | Í. |
|--|---|------------------------------------|-----------------------|----------------------------------|----------------------|
| tuarial Value - A' | V Calculator | 90.7% <u>91.2</u> | 10% | 88.8% <u>89.4</u> | 1% |
| | 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 / \$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 | |
| | HSA family plan: Individual deductible | N/A | | N/A | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductibl 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 | |
| | Tier 2 | \$25 | | \$20 | |
| Drugs to reat illness | | \$25 | | \$20 | |
| 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 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 immediate attention | Medical transportation (including emergency and non-emergency) | \$150 | | \$150 | |
| | 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 nealth, pehavioral | Mental/behavioral health and substance use disorder outpatient office visits | \$15 | | \$20 | |
| nealth, 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 | |
| | Home health care (cost share per visit) | 10% | | \$20 | |
| Help | Outpatient Rehabilitation and Habilitation services | \$15 | | \$20 | |
| 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 | Eye exam | No charge | | No charge | |
| | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | Oral Exam | | | | |
| Child Dental | Preventive - Cleaning | | | | |
| Diagnostic | Preventive - X-ray | Not Covered | | Not Covered | |
| and Preventive | Sealants per Tooth | | | | |
| | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| Child Dental | Restorative Procedures | N-+ O | | Net O | |
| Basic Services | Periodontal Maintenance Services | Not Covered | | Not Covered | |
| | Crowns and Casts | | | | |
| | | | | | |

Not Covered

Not Covered

Not Covered

Not Covered

Date: June 16, 2022 April 20, 2023

| mber Cost Share | amounts describe the Enrollee's out of pocket costs. | Individual-only Coinsurance | | Individual-only Copay Pla | |
|--|--|----------------------------------|-----------------------|---------------------------------|------------------|
| uarial Value - A' | V Calculator | 81.9% | | 80.1% 81.5 | ;% |
| | Plan design includes a deductible? | No | | No | .,. |
| | Integrated Individual deductible | \$0 | | \$0 | |
| | Integrated Family deductible | | | | |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$0 / \$0 / \$ | D | \$0 / \$0 / \$ | 0 |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$0 / \$0 / \$ | C | \$0 / \$0 / \$ | 0 |
| | Individual Out–of–pocket maximum | \$8,550 <u>\$8.7</u> | | \$8,550 <u>\$8,7</u> | |
| | Family Out-of-pocket maximum | \$17,100 <u>\$17,</u> | | \$17,100 <u>\$17</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 | Deduct Applie |
| | Primary care visit to treat an injury, illness, or condition | \$35 | | \$35 | |
| lealth care provider's office or | Other practitioner office visit | \$35 | | \$35 | |
| linic visit | Specialist visit | \$65 | | \$65 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests | \$40 | | \$40 | |
| ests | X-rays and Diagnostic Imaging | \$75 | | \$75 | |
| | Imaging (CT/PET scans, MRIs) | 25% | | | |
| | | | | \$75 | |
| | Tier 1 | \$15 | | \$15 | |
| | Tier 2 | \$60 | | \$60 | |
| Drugs to reat illness | | | | | |
| or condition | Tier 3 | \$85 | | \$85 | |
| | Tier 4 | 20% up to \$250 per script | | 20% up to \$250 per script | |
| | Surgery facility fee (e.g., ASC) | 20% 30% | | \$150 <u>\$130</u> | |
| Dutpatient | Physician/surgeon fees | 20% 30% | | \$40 | |
| ervices | 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 | |
| attention | | | | | |
| | Urgent care | \$35 | | \$35 | |
| | | | | | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 30% | | \$350 \$330 per day | |
| lospital stay | delivery, mental health, and substance use) | 3078 | | up to 5 days | |
| | Physician/surgeon fee | 30% | | No charge | |
| Mental nealth, | Mental/behavioral health and substance use disorder outpatient office | \$35 | | \$35 | |
| pehavioral | visits | <i>Q</i> OO | | \$00 | |
| nealth, or substance | Mental/behavioral health and substance use disorder other outpatient items and services | \$35 | | \$35 | |
| buse needs Pregnancy | Prenatal care and preconception visits | No charge | | No charge | |
| | Home health care (cost share per visit) | 20% | | \$30 | |
| | | | | | |
| lelp ecovering or | Outpatient Rehabilitation and Habilitation services | \$35 | | \$35 \$150 per day up to | |
| other special | Skilled nursing care | 30% | | 5 days | |
| ealth needs | Durable medical equipment | 20% | | 20% | |
| | Hospice service | No charge | | No charge | |
| Child eye | Eye exam | No charge | | No charge | |
| are | rair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | Oral Exam | | | | |
| | | | | | |
| Child Dental | Preventive - Cleaning | | | | |
| Diagnostic | Preventive - X-ray | Not Covered | | Not Covered | |
| ind 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 | | | | |
| | | | | | |
| Child Dental | Endodontics | | | | |
| Major Services | Periodontics (other than maintenance) | Not Covered | | Not Covered | |
| | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| Child | | Not Covered | | Not Covered | |

| ummary of Ber | nefits and Coverage | CCSB-only | | CCSB-only | | |
|--|--|--|-----------------------|-------------------------------|---------------------|--|
| lember Cost Share | amounts describe the Enrollee's out of pocket costs. | Gold Coinsurance Plar | ı | Gold Copay Plan | | |
| | | | | | | |
| tuarial Value - A | V Calculator | 78.9% | | 80.5% <u>80.7%</u> | | |
| | Plan design includes a deductible? | Yes, Medical/Pharma | асу | Yes, Medical/Pharr | macy | |
| | Integrated Individual deductible Integrated Family deductible | N/A | | N/A | | |
| | Integrated Family deductible, NOT integrated: Medical / Pharmacy / Dental | N/A | | N/A | | |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$350 / \$0 / \$0 \$700 / \$0 / \$0 | | \$500 / \$0 / \$0 | \$250 / \$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 | | |
| | HSA family plan: Individual deductible | N/A | | N/A | | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductit Applies | |
| Lvent | Primary care visit to treat an injury, illness, or condition | \$25 | | \$35 | | |
| Health care | | A 07 | | 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 | х | |
| | Tier 1 | \$15 | | \$15 | | |
| | | σιφ | | σιφ | | |
| 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 | | |
| | | | | | | |
| Outpotiont | 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% | х | \$250 | х | |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | | |
| Need | Medical transportation (including emergency and non-emergency) | 20% | х | \$250 | х | |
| immediate attention | | 6 05 | | | | |
| | Urgent care | \$25 | | \$35 | | |
| line it i | Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) | 20% | х | \$600 per day up to 5 days | х | |
| Hospital stay | Physician/surgeon fee | 20% | х | No charge | | |
| Mental health, behavioral health, or substance | Mental/behavioral health and substance use disorder outpatient office visits | \$25 | | \$35 | | |
| | Mental/behavioral health and substance use disorder other outpatient | \$25 | | \$35 | | |
| abuse needs | items and services | ΨZIJ | | ψου | | |
| 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 other special | Skilled nursing care | 20% | х | \$300 per day up to 5 days | х | |
| health needs | Durable medical equipment | 20% | | 20% | | |
| | Hospice service | No charge | | No charge | | |
| Ohill | 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 | no onarge | | no onarge | | |
| | | | | | | |
| 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 | NUL COVEIEU | | NOL COVEIEU | | |
| | Crowns and Casts | | | | | |
| | Endodontics | | | | | |
| Child Dental | | | | Not Covered | | |
| | Periodontics (other than maintenance) | Not Covered | | Not Covered | | |
| Child Dental Major Services | Periodontics (other than maintenance) Prosthodontics | Not Covered | | Not Covered | | |
| Major | Periodontics (other than maintenance) Prosthodontics Oral Surgery | Not Covered | | Not Covered | | |

2023 20 Designs 9.5 EHB

Date: June 16, 2022 April 20, 2023 Summary of Benefits and Coverage Individual-only Silver Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Yes, Medical/Pharmacy 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 2 HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Commor Medical Service Type Member C Event Primary care visit to treat an injury, illness, or condition \$45 Health care provider's office or clinic visit Other practitioner office visit \$45 \$50 Specialist visit Preventive care/ screening/ immunization No charge Laboratory Tests Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)

Tier 2 Drugs to treat illness or condition Tier 3 Tier 4 Surgery facility fee Outpatient services Physician/surg Outpatient visi Emergency roo Emergency roo Medical transp Need immediate attention Urgent care

Tier 1

Hospital stay Mental health, behavioral health, or substance abuse needs Prenatal care and preconception visits Pregnancy Help recovering or other special health needs

Eye exam Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Restorative Procedures Periodontal Maintenance Services Services Crowns and Casts

Child Dental Major

Services

Child

Orthodo

Endodontics

Prosthodontics Oral Surgery

Periodontics (other than maintenance)

Medically necessary orthodontics

Facility f delivery Physicia Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services

Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service

| | \$60 |
|----------|--|
| | \$90 |
| | 20% up to \$250 per script after pharmacy deductible |
| g., ASC) | 20% 30% |

| | 20% up |
|-------------|---------------------|
| | 20% up after pha |
| (e.g., ASC) | |

| | 20% up to \$250 pe after pharmacy dec |
|------|--|
| ASC) | 20% 30% |
| | 20% 30% |
| | 20% 30% |

| | 20% after |
|---------------------------|--------------|
| , ASC) | |
| | |
| (fee (weived if admitted) | |

| | а |
|-----------------------------------|---|
| e (e.g., ASC) | |
| n fees | |
| | |
| facility fee (waived if admitted) | |

| geon fees | |
|---|--|
| it | |
| oom facility fee (waived if admitted) | |
| oom physician fee (waived if admitted) | |
| portation (including emergency and non-emergency) | |

| ysician fee (waived if admitted) | |
|--|--|
| on (including emergency and non-emergency) | |
| | |
| | |
| | |

| tion (including emergency and non-emergency) | |
|--|--|
| | |
| | |

| fee (e.g. hospital room) for inpatient stay (including labor and , mental health, and substance use) | |
|---|--|
| an/surgeon fee | |
| | |

| spital room) for inpatient stay (including labor and alth, and substance use) | |
|--|--|
| 20 | |

| ospital room) for inpatient stay (including labor and ealth, and substance use) | |
|---|--|
| | |

| \$16 |
|-----------------|
| \$60 |

| \$95 | |
|-------|--|
| \$325 | |

\$400 \$450

No charge

\$250

\$45 \$50

30%

30%

No charge

\$45

30%

20%

No charge

No charge

No charge

Not Covered

Not Covered

Not Covered

Not Covered

| \$50 | | |
|------|--|--|
| \$95 | | |

Pharmacy deductible

Pharmacv

deductible Pharmacy

deductible

Pharmacy

deductible

х

х

| <u>\$50</u> | |
|-------------|--|

| N/A | |
|------------|-----------------------|
| Cost Share | Deductible Applies |

| 17,500 <u>\$18,200</u> N/A | |
|--|--|
| N/A | |
| NI/A | |

| <u>)</u> \ \$110 <u>\$300</u> \ \$0 | |
|--|--|
| 0 <u>\$9,100</u> | |
| Ө <u>\$18,200</u> | |

N/A

\$9,500 <u>\$10,800</u> / \$170 <u>\$300</u> / \$0

\$8,75

N/A \$4,750 <u>\$5,400</u> / \$85 <u>\$150</u> / **\$**0

| <u>)24</u> | Patient-Centered | Benefit | Plan | 0 |
|------------|------------------|---------|------|---|
| 3 | | | | |

Date: June 16, 2022 April 20, 2023

| - | nefits and Coverage amounts describe the Enrollee's out of pocket costs. | CCSB-only Silver Coinsurance Plar | 1 | CCSB-only Silver Copay Plan | |
|--|---|---|------------------------|---|---------------------|
| tuarial Value - A | V Calculator | 71.9% <u>70.0%</u> | | 71.7% <u>69.7%</u> | |
| | Plan design includes a deductible? | Yes, Medical/Pharma | су | 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 | \$2,500 / \$300 / \$0 | | \$2,500 / \$300 / \$0 |) |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$5,000 / \$600 / \$0 | | \$5,000 / \$600 / \$6 |) |
| | Individual Out-of-pocket maximum | \$8,600 | | \$8,750 | |
| | Family Out-of-pocket maximum | \$17,200 | | \$17,500 | |
| | HSA plan: Self-only coverage deductible | N/A | | N/A | |
| Common | HSA family plan: Individual deductible | N/A | | N/A | |
| Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductit Applies |
| | Primary care visit to treat an injury, illness, or condition | \$55 | | \$55 | |
| Health care provider's | Other practitioner office visit | \$55 | | \$55 | |
| office or | 2 | | | | |
| clinic visit | Specialist visit | \$90 | | \$90 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests | \$55 | | \$55 | |
| Tests | X-rays and Diagnostic Imaging | \$90 | | \$90 | |
| | Imaging (CT/PET scans, MRIs) | 35% | х | \$300 | х |
| | Tier 1 | \$20 | | \$19 | |
| | | \$20 | | ข้าล | |
| Drugs to | Tier 2 | \$75 | Pharmacy deductible | \$85 | Pharm: deducti |
| treat illness | Tior 3 | 0 405 | Pharmacy | 6440 | Pharm |
| or condition | Tier 3 | \$105 | deductible | \$110 | deducti |
| | Tier 4 | 30% up to \$250 per script after pharmacy deductible | Pharmacy deductible | 30% up to \$250 per script after pharmacy deductible | Pharm: deducti |
| | Surgery facility fee (e.g., ASC) | 35% | х | 35% | Х |
| Outpatient | Physician/surgeon fees | 35% | | 30% 35% | |
| services | Outpatient visit | 35% | | 30% 35% | |
| | | | | | |
| | Emergency room facility fee (waived if admitted) | 35% | Х | 30% 35% | Х |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| Need immediate | Medical transportation (including emergency and non-emergency) | 35% | Х | 30% 35% | Х |
| attention | Urgent care | \$55 | | \$55 | |
| | | | | | |
| Hospital stay | Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) | 35% | Х | 40% 35% | Х |
| nospital stay | Physician/surgeon fee | 35% | х | 40% 35% | |
| Mental | Mantal/bahaviaral baalth and substance use disorder outpatient office | | | | |
| health, behavioral | Mental/behavioral health and substance use disorder outpatient office visits | \$55 | | \$55 | |
| health, or substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$55 | | \$55 | |
| Pregnancy | Prenatal care and preconception visits | No charge | | No charge | |
| | Home health care (cost share per visit) | 35% | | \$45 | |
| | | | | | |
| Help recovering or | Outpatient Rehabilitation and Habilitation services | \$55 | | \$55 | |
| other special | Skilled nursing care | 35% | Х | 40% 35% | Х |
| health needs | Durable medical equipment | 35% | | 40% 35% | |
| | Hospice service | No charge | | No charge | |
| Child out | Eye exam | No charge | | No charge | |
| Child eye care | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | | no onarge | | no chaige | |
| | Oral Exam | | | | |
| 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 | | Not Covered | | Not Covered | |
| Services | Periodontal Maintenance Services | | | | |
| | Crowns and Casts | | | | |
| | | | | 1 | |
| | Endodontics | | | | |
| Child Dental Major | Endodontics Periodontics (other than maintenance) | Not Covered | | Not Covered | |
| Child Dental Major | Periodontics (other than maintenance) | Not Covered | | Not Covered | |
| Child Dental | | Not Covered | | Not Covered | |

Date: June 16, 2022 April 20, 2023

Child Orthodontics

Medically necessary orthodontics

| - | nefits and Coverage amounts describe the Enrollee's out of pocket costs. | CCSB-o Silver HDHP Pl | | |
|--|---|-------------------------------------|------------------|--|
| tuarial Value - A' | V Calculator | 71.7% | | |
| | Plan design includes a deductible? | Yes, integr | | |
| | Integrated Individual deductible | \$2,700 <u>\$2,850</u> i | • | |
| | Integrated Family deductible | \$5,400 <u>\$5,700</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 | \$7,200 <u>\$7</u> | ,500 | |
| | Family Out-of-pocket maximum | | | |
| | HSA plan: Self-only coverage deductible | | | |
| | HSA family plan: Individual deductible | See endn | | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Appli | |
| | Primary care visit to treat an injury, illness, or condition | 25% | х | |
| Health care provider's | Other practitioner office visit | 25% | x | |
| office or | | | | |
| clinic visit | Specialist visit | 25% | Х | |
| | Preventive care/ screening/ immunization | No charge | | |
| | Laboratory Tests | 25% | Х | |
| Tests | X-rays and Diagnostic Imaging | 25% | х | |
| | Imaging (CT/PET scans, MRIs) | 25% | х | |
| | Tier 1 | 25% up to \$250 per | х | |
| | | script | Å | |
| Drugs to | Tier 2 | 25% up to \$250 per script | х | |
| reat illness | Tier 3 | 25% up to \$250 per | v | |
| or condition | | script | Х | |
| | Tier 4 | 25% up to \$250 per script | х | |
| | Surgery facility fee (e.g., ASC) | 25% | х | |
| Outpatient | Physician/surgeon fees | 25% | x | |
| services | | | | |
| | Outpatient visit | 25% | Х | |
| | Emergency room facility fee (waived if admitted) | 25% | Х | |
| | Emergency room physician fee (waived if admitted) | 0% | Х | |
| Need Immediate attention | Medical transportation (including emergency and non-emergency) | 25% | х | |
| | Urgent care | 25% | х | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | | | |
| Hospital stay | delivery, mental health, and substance use) | 25% | Х | |
| | Physician/surgeon fee | 25% | Х | |
| Mental nealth, pehavioral | Mental/behavioral health and substance use disorder outpatient office visits | 25% | х | |
| health, or substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | 25% | х | |
| Pregnancy | Prenatal care and preconception visits | No charge | | |
| | Home health care (cost share per visit) | 25% | х | |
| lelp | Outpatient Rehabilitation and Habilitation services | 25% | х | |
| ecovering or | Skilled nursing care | 25% | x | |
| other special nealth needs | - | | | |
| | Durable medical equipment | 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 | Preventive - X-ray | | | |
| Diagnostic and | Sealants per Tooth | Not Covered | | |
| Preventive | | | | |
| | Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic | Restorative Procedures | Not Covered | | |
| Services | Periodontal Maintenance Services | | | |
| | Crowns and Casts | | | |
| | Endodontics | | | |
| Child Dental Major | Periodontics (other than maintenance) | Not Covered | | |
| Services | | | | |
| | Prosthodontics | | | |
| Child | Oral Surgery | | | |
| | | | | |

Not Covered

Date: June 16, 2022 <u>April 20, 2023</u> Summary of Benefits and Coverage

| ember Cost Share | amounts describe the Enrollee's out of pocket costs. | Silver P 100%-1509 | | Silver Plan 150%-200% FPI | L |
|--|--|------------------------------|-----------------------|--|---------------------|
| tuarial Value - A | V Calculator | 94.9% | , | 87.9% | |
| alue - A | Plan design includes a deductible? | 94.9% Yes, Medical/F | | Yes, Medical/Pharm | hacy |
| | Integrated Individual deductible | N/A | lannaoy | N/A | |
| | Integrated Family deductible | N/A | | N/A | |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$75 / \$0 / \$0 | | \$800 / <u>\$25</u> <u>\$50</u> / \$0 | |
| Family deductible, NOT integrated: Medical / Pharmacy / Dental | | \$150 / \$0 / \$0 | | \$1,600 / \$50 <u>\$100</u> / \$0 | |
| | Individual Out-of-pocket maximum | \$900 <u>\$1.</u> | <u>150</u> | \$3,000 <u>\$3,150</u> | |
| | Family Out-of-pocket maximum | \$1,800 | 2,300 | \$6,000 | |
| | 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 | Deductib Applies |
| Event | Primary care visit to treat an injury, illness, or condition | \$5 | | \$15 | |
| lealth care provider's | Other practitioner office visit | \$5 | | \$15 | |
| ffice or linic visit | | | | 007 | |
| | Specialist visit | \$8 | | \$25 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests | \$8 | | \$20 | |
| ests | X-rays and Diagnostic Imaging | \$8 | | \$40 | |
| | Imaging (CT/PET scans, MRIs) | \$50 | | \$100 | |
| | Tier 1 | \$3 | | \$5 \$6 | Pharma deductik |
| | Tior 2 | ¢40 | | ¢05 | Pharma |
| rugs to reat illness | Tier 2 | \$10 | | \$25 | deductib |
| r condition | Tier 3 | \$15 | | \$45 | Pharma deductib |
| | Tier 4 | 10% up to \$150 per | | 15% up to \$150 per script | Pharma |
| _ | | script | | | deductik |
| Outpatient | Surgery facility fee (e.g., ASC) | 10% | | 15% 20% | |
| ervices | Physician/surgeon fees | 10% | | 15% 20% | |
| | Outpatient visit | 10% | | 15% 20% | |
| | Emergency room facility fee (waived if admitted) | \$50 | | \$150 | |
| | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| Need immediate attention | Medical transportation (including emergency and non-emergency) | \$30 | | \$75 | |
| | Urgent care | \$5 | | \$15 | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 10% | х | 25% 20% | х |
| lospital stay | delivery, mental health, and substance use) Physician/surgeon fee | 10% | | 25% 20% | |
| Mental lealth, lehavioral | Mental/behavioral health and substance use disorder outpatient office visits | \$5 | | \$15 | |
| ealth, or substance subse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$5 | | \$15 | |
| regnancy | Prenatal care and preconception visits | No charge | | No charge | |
| | Home health care (cost share per visit) | \$3 | | \$15 | |
| ala | Outpatient Rehabilitation and Habilitation services | \$5 | | \$15 | |
| lelp ecovering or | | | N. | 913 25% 20% | |
| ther special ealth needs | Skilled nursing care | 10% | Х | | X |
| | Durable medical equipment | 10% | | 15% | |
| | Hospice service | No charge | | No charge | |
| hild eye | Eye exam | No charge | | No charge | |
| are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | Oral Exam | | | | |
| | Preventive - Cleaning | | | | |
| hild Dental | Preventive - X-ray | | | | |
| nd | Sealants per Tooth | Not Covered | | Not Covered | |
| reventive | Topical Fluoride Application | | | | |
| | Space Maintainers - Fixed | | | | |
| hild Dental | Restorative Procedures | | | | |
| asic Services | Restorative Procedures Periodontal Maintenance Services | Not Covered | | Not Covered | |
| CI VICES | Crowns and Casts | | | | |
| | Endodontics | | | | |
| Child Dental Najor | | Not Covered | | Not Covered | |
| Najor Services | Periodontics (other than maintenance) | NUL COVEIED | | | |
| | Prosthodontics | | | | |
| | Oral Surgery | | | | |
| Child | Medically necessary orthodontics | Not Covered | | Not Covered | |

Date: June 16, 2022 April 20, 2023

| ember Cost Share | amounts describe the Enrollee's out of pocket costs. | Silver Plan 200%-250% FPI | - |
|----------------------------|--|--|---------------------|
| tuarial Value - A | V Calculator | 73.9% 74.0% | |
| | 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 | \$4,750 | <u>50</u> / \$0 |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$9,500 | <u>300</u> / \$0 |
| | Individual Out–of–pocket maximum | \$7,250 <u>\$7,550</u> | |
| | Family Out-of-pocket maximum | \$14,500 <u>\$15,100</u> | <u>)</u> |
| | HSA plan: Self-only coverage deductible | N/A | |
| 2 | 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 | \$45 <u>\$50</u> | |
| Health care provider's | Other practitioner office visit | \$45 | |
| office or clinic visit | Specialist visit | ¢95 ¢00 | |
| | | \$85 | |
| _ | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | \$50 | |
| Tests | X-rays and Diagnostic Imaging | \$90 | |
| | Imaging (CT/PET scans, MRIs) | \$325 | |
| | Tier 1 | \$16 | Pharma deductit |
| | Tior 2 | <i><i><i><i></i></i></i><i></i></i><i></i> | Pharma |
| Drugs to treat illness | Tier 2 | \$55 | deductit |
| or condition | Tier 3 | \$85 | Pharma deductib |
| | - | 20% up to \$250 per script | Pharma |
| | Tier 4 | after pharmacy deductible | deductik |
| | Surgery facility fee (e.g., ASC) | 20% 30% | |
| Outpatient services | Physician/surgeon fees | 20% 30% | |
| 501 11000 | Outpatient visit | 20% 30% | |
| | Emergency room facility fee (waived if admitted) | \$400 \$450 | |
| | Emergency room physician fee (waived if admitted) | No charge | |
| Need | Medical transportation (including emergency and non-emergency) | \$250 | |
| immediate | | ψ230 | |
| attention | Urgent care | \$45 \$50 | |
| | | Q10 Q00 | |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 30% | x |
| Hospital stay | delivery, mental health, and substance use) | 2001 | |
| | Physician/surgeon fee | 30% | |
| Mental health, | Mental/behavioral health and substance use disorder outpatient office visits | \$45 <u>\$50</u> | |
| behavioral health, or | Noko | | |
| substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$4 5 | |
| Pregnancy | Prenatal care and preconception visits | No charge | |
| | Home health care (cost share per visit) | \$40 | |
| Holp | Outpatient Rehabilitation and Habilitation services | \$45 <u>\$50</u> | |
| Help recovering or | | | |
| other special health needs | Skilled nursing care | 30% | X |
| | 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 | | Not Covered | |
| Services | Periodontal Maintenance Services | | |
| | Crowns and Casts | | |
| Child Dental | Endodontics | | |
| Major Services | Periodontics (other than maintenance) | Not Covered | |
| Jei vices | Prosthodontics | | |
| | Oral Surgery | | |
| | | | |

Date: June 16, 2022 April 20, 2023

| ember Cost Share | amounts describe the Enrollee's out of pocket costs. | Bronze Plan | | Bronze HDHP Pla | n |
|--|---|---|---|--|-------------------|
| tuarial Value - A | V Calculator | 64 70/ 64 40/ | | 64.2%_64.9 | % |
| tuariai value - A | | 64.7% 64.4% | 2004 | | |
| | Plan design includes a deductible? Integrated Individual deductible | Yes, Medical/Pharmacy N/A | | Yes, integrated \$7,000 <u>\$7,050</u> integrated | |
| Integrated Individual deductible | | N/A | | \$14,000 \$14,100 integrated | |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | \$6,300 / \$500 / \$0 | | N/A | |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | \$12,600 / \$1,000 | / \$0 | N/A | |
| | Individual Out–of–pocket maximum | \$8,200 \$9,100 | | \$7,000 \$7,0 | 50 |
| | Family Out-of-pocket maximum | \$16,400 \$18,20 | 0 | \$14,000 \$14, | 100 |
| | HSA plan: Self-only coverage deductible | N/A | | \$7,000 \$7,0 | 50 |
| Common | HSA family plan: Individual deductible | N/A | | \$7,000 \$7,050 | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deducti Applie |
| laaliih aara | Primary care visit to treat an injury, illness, or condition | \$65 <u>\$60</u> | After 1st three non- preventive visits | 0% | х |
| Health care provider's | Other practitioner office visit | \$65 | After 1st three non- preventive visits | 0% | х |
| office or clinic visit | Specialist visit | \$95 | After 1st three non- | 0% | х |
| | Preventive care/ screening/ immunization | No charge | preventive visits | No charge | |
| | Laboratory Tests | \$40 | | 0% | х |
| Tests | X-rays and Diagnostic Imaging | 40% | x | 0% | x |
| | Imaging (CT/PET scans, MRIs) | 40% | X | 0% | x |
| | | | | | |
| | Tier 1 | \$18 \$17 | Pharmacy Deductible | 0% | Х |
| Drugs to | Tier 2 | 40% up to \$500 per script after pharmacy deductible | Pharmacy Deductible | 0% | х |
| reat illness | Tier 3 | 40% up to \$500 per script after | Pharmacy | 0% | х |
| , condition | | pharmacy deductible | Deductible | υ% | X |
| | Tier 4 | 40% up to \$500 per script after pharmacy deductible | Pharmacy Deductible | 0% | х |
| | Surgery facility fee (e.g., ASC) | 40% | X | 0% | х |
| Dutpatient | | | | | |
| ervices | Physician/surgeon fees | 40% | X | 0% | Х |
| | Outpatient visit | 40% | х | 0% | Х |
| | Emergency room facility fee (waived if admitted) | 40% | Х | 0% | Х |
| | Emergency room physician fee (waived if admitted) | No charge | | 0% | Х |
| 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 |
| | Facility fee (e.g. hospital room) for inpatient stay (including labor and | 40% | х | 0% | х |
| lospital stay | delivery, mental health, and substance use) Physician/surgeon fee | 40% | x | 0% | х |
| Mental nealth, pehavioral | Mental/behavioral health and substance use disorder outpatient office visits | \$ 65 | After 1st three non- preventive visits | 0% | х |
| nealth, or substance abuse needs | Mental/behavioral health and substance use disorder other outpatient items and services | \$ 65 | × | 0% | х |
| Pregnancy | Prenatal care and preconception visits | No charge | | No charge | |
| | Home health care (cost share per visit) | 40% | x | 0% | х |
| | Outpatient Rehabilitation and Habilitation services | \$ 65 <u>\$60</u> | | 0% | x |
| lelp ecovering or | | | v | | |
| other special lealth needs | Skilled nursing care | 40% | X | 0% | X |
| | Durable medical equipment | 40% | X | 0% | Х |
| | Hospice service | No charge | | 0% | Х |
| 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 | | | | |
| bild Dental | Preventive - Cleaning | | | | |
| Child Dental Diagnostic | Preventive - X-ray | Not Covered | | Not Covered | |
| nd 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 Maior | Periodontics (other than maintenance) | Not Covered | | Not Covered | |
| Major Services | | | | | |
| Services | Prosthodontics | | | | |
| Services | Prosthodontics Oral Surgery | | | | |

Date: June 16, 2022 April 20, 2023 Summary of Benefits and Coverage

| - | nefits and Coverage amounts describe the Enrollee's out of pocket costs. | Catast | rophic Plan |
|---|--|-------------------|---|
| | V Calculator | | |
| tuarial Value - A | V Calculator Plan design includes a deductible? | Ves | integrated |
| | Integrated Individual deductible | | 0,450 integrated |
| | Integrated monotonic deductible | | 8,900 integrated |
| | Individual deductible, NOT integrated: Medical / Pharmacy / Dental | | N/A |
| | Family deductible, NOT integrated: Medical / Pharmacy / Dental | | N/A |
| | Individual Out–of–pocket maximum | \$9,1 | 00 |
| | Family Out-of-pocket maximum | \$18,2 | 00 <u>\$18,900</u> |
| | HSA plan: Self-only coverage deductible | | |
| Common | HSA family plan: Individual deductible | Member Cost | |
| Medical Event | Service Type | Share | Deductible Applie After 1st three no |
| lealth care | Primary care visit to treat an injury, illness, or condition | 0% | preventive visit |
| provider's office or clinic visit | Other practitioner office visit | 0% | preventive visit |
| clinic visit | Specialist visit | 0% | Х |
| _ | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | 0% | X |
| lests . | X-rays and Diagnostic Imaging | 0% | X |
| | Imaging (CT/PET scans, MRIs) | 0% | Х |
| | Tier 1 | 0% | х |
| Drugs to reat illness | Tier 2 | 0% | Х |
| or condition | Tier 3 | 0% | Х |
| | Tier 4 | 0% | х |
| Dutpatient | Surgery facility fee (e.g., ASC) | 0% | х |
| services | Physician/surgeon fees | 0% | Х |
| | Outpatient visit | 0% | Х |
| | Emergency room facility fee (waived if admitted) | 0% | Х |
| | Emergency room physician fee (waived if admitted) | No charge | |
| Need mmediate attention | Medical transportation (including emergency and non-emergency) | 0% | х |
| | Urgent care | 0% | After 1st three no preventive visits |
| la anital atau | Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) | 0% | х |
| lospital stay | Physician/surgeon fee | 0% | х |
| lental nealth, | Mental/behavioral health and substance use disorder outpatient office visits | 0% | After 1st three no preventive visit |
| ehavioral nealth, or substance | Mental/behavioral health and substance use disorder other outpatient | 0% | x |
| abuse needs | items and services | 070 | ~ |
| regnancy | Prenatal care and preconception visits | No charge | |
| | Home health care (cost share per visit) | 0% | х |
| lelp | Outpatient Rehabilitation and Habilitation services | 0% | х |
| ecovering or other special | Skilled nursing care | 0% | х |
| ealth needs | Durable medical equipment | 0% | х |
| | Hospice service | 0% | х |
| Child eye | Eye exam | No charge | |
| are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | 0% | х |
| | Oral Exam | | |
| Child Dental | Preventive - Cleaning | | |
| Diagnostic | Preventive - X-ray | Not Covered | |
| ind Preventive | Sealants per Tooth | | |
| | Topical Fluoride Application | | |
| | Space Maintainers - Fixed | | |
| Child Dental Basic | Restorative Procedures | Not Covered | |
| Services | Periodontal Maintenance Services | | |
| | Crowns and Casts | | |
| Child Dental | Endodontics | | |
| Major | Periodontics (other than maintenance) | Not Covered | |
| Services | Prosthodontics | | |
| | Oral Surgary | | |

Child Orthodont Oral Surgery

Medically necessary orthodontics

Not Covered

Endnotes to Covered California 2023 2024 Patient-Centered Benefit Plan Designs

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

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2023 2024 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; 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.
- A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California <u>2023</u> <u>2024</u> 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, <u>Podiatrists</u>, 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) Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (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. | | | |
| | a druge may be subject to zero east shoring under the proven | | | |

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 out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2023 2024 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.