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>		-		,	_	
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<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.