Covered California 2023 2024 Patient-Centered Benefit Plan Designs¹

Final Board-approved Revised

Final AV Calculator and

Notice of Benefit and Payment Parameters for 2024 Final Rule

June 16, 2022

May 18, 2023

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

Date: June 16, 2022 May 18, 2023 Summary of Benefits and Coverage



Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Individual-only F Coinsurance		Individual-only Platinum Copay Plan	
Actuarial 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 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum			\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common					
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	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	
treat illness or condition	Tier 3	\$25		\$25	
or containon					
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100 \$75	
Outpatient services	Physician/surgeon fees	10%		\$25 <u>\$20</u>	
Services	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	
immediate attention	,	\$100		ψ100	
attention	Urgent care	\$15		\$15	
	Organic date	ψ13		Ψισ	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	400/		\$250 \$225 per day	
Hospital stay	delivery, mental health, and substance use)	10%		up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
behavioral	visits				
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
abuse needs					
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help .	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or other special	Skilled nursing care	10%		\$150 \$125 per day up to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2023 <u>2024</u>	
Basic Services	Periodontal Maintenance Services	20%		Dental Copay Schedule	
OCI VICES	Crowns and Casts			Soriculit	
	Endodontics				
Child Dental		50%		See 2023 2024	
Major Services	Periodontics (other than maintenance)	JU%		Dental Copay Schedule	
	Prosthodontics Oral Surgary				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2023 2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: June 16, 2022 May 18, 2023

Date: June 16	i, 2022 <u>May 18, 2023</u>				
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	Ĭ
Actuarial Value - A	V Calculator	90.7% <u>91.2</u>	%	88.8% <u>89.4</u>	!%
7 totadrial value 71	Plan design includes a deductible?	No	. <u>.70</u>	No	<u> 70</u>
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit	\$30		\$30	
Cillio Visit					
	Preventive care/ screening/ immunization	No charge		No charge	
Tanta	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to	Tier 2	\$25		\$20	
treat illness	Time	• • •			
or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
0.40.450.04	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate attention					
	Urgent care	\$15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	1070		. to onargo	
health, behavioral	visits	\$15		\$20	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs	•			5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2023 2024 Dental Copay	
Services	Periodontal Maintenance Services	2070		Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2023 2024	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics					

tuarial Value - A\	/ Calculator Plan design includes a deductible?	81.9%			
uaniai value - A		01.976		80.1% <u>81.5</u>	TO/
		No		80.1% <u>81.5</u> No	<u>1%</u>
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$.0
	Individual Out-of-pocket maximum	\$8,550 <u>\$8,7</u> 0	<u>)0</u>	\$8,550 <u>\$8,7</u>	<u>'00</u>
	Family Out-of-pocket maximum	\$ 17,100 <u>\$17,</u> 4	<u>400</u>	\$17,100 <u>\$17</u> ,	400
	HSA plan: Self-only coverage deductible	N/A		N/A	
_	HSA family plan: Individual deductible	e N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applie
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
dealth care provider's office or	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
ests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
Orugs to	Tier 2	\$60		\$60	
reat illness or condition	Tier 3	\$85		\$85	
or condition	Tier 4	20% up to \$250 per		20% up to \$250 per	
		script		script	
Outpatient	Surgery facility fee (e.g., ASC)	20% 30%		\$150 <u>\$130</u>	
services	Physician/surgeon fees	20% 30%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$35		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	30%		\$350 \$330 per day up to 5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	30%		No charge	
nealth, pehavioral nealth, or	visits	\$35		\$35	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
recovering or other special	Skilled nursing care	30%		\$150 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed Restorative Procedures			See- 2023 2024	
Basic	Periodontal Maintenance Services	20%		Dental Copay Schedule	
Services	Periodontal Maintenance Services Crowns and Casts			Scriedule	
Child Dental	Endodontics	F00/		See 2023 2024	
Major Services	Periodontics (other than maintenance)	50%		Dental Copay Schedule	
	Prosthodontics				
Child	Oral Surgery				

	5, 2022 <u>May 18, 2023</u>				
-	nefits and Coverage	CCSB-only Gold		CCSB-only Gold	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance Pla	n	Copay Plan	
Actuarial Value - A		78.9% <u>78.8%</u>		80.5% <u>80.7%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum	\$700 / \$0 / \$0		\$500 / \$0 / \$0 \$7,800	
	Family Out-of-pocket maximum	\$7,800 \$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible			N/A	
Common			Deductible		Deductible
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care					
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	
Drugs to	Tier 2	\$50		\$40	
treat illness or condition	Tier 3	\$80		\$70	
or condition	1010	φου		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient					^
services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х
attention					
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	Х
Hospital stay	Physician/surgeon fee	20%	x	No charge	
Mental		2076	^	ivo charge	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
behavioral health, or					
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
	Proposal care and preconception visits	No shares		No sharas	
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%	x	\$300 per day up to 5 days	Х
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	·				
	Topical Fluoride Application				
Child David	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2023 2024 Dental Copay Schedule	
Services	Periodontal Maintenance Services			Gorieutie	
	Crowns and Casts				
Child Dental	Endodontics			Son 2022 2024 Death 1 2	
Major Services	Periodontics (other than maintenance)	50%		See 2023 2024 Dental Copay Schedule	
OCI VICES	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	
Orthodontics					

Summary	of Re	nefite	and i	Coverage

=	nefits and Coverage	Individual cult Citys	Dlan
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Pian
Actuarial Value - A	NV Calculator	71.6% <u>71.8%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 4,750 <u>\$5,400</u> / \$85 <u>\$1</u>	<u>50</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 9,500 <u>\$10,800</u> /- \$170 <u>\$</u>	<u>300</u> / \$0
	Individual Out–of–pocket maximum	\$ 8,750 <u>\$9,100</u>	
	Family Out-of-pocket maximum	\$ 17,500 <u>\$18,200</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible
Event	Primary care visit to treat an injury, illness, or condition	\$45 <u>\$50</u>	Applies
Health care	Other practitioner office visit	\$45 \$50	
provider's office or		\$43 <u>\$30</u>	
clinic visit	Specialist visit	\$85 <u>\$90</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16 <u>\$19</u>	Pharmacy deductible
	Tier 2		Pharmacy
Drugs to treat illness	Her Z	\$60	deductible
or condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy
	Hel 4	after pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	20% -30%	
Outpatient 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 <u>\$50</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	
Mental		30 %	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$45 <u>\$50</u>	
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$4 5 <u>\$50</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$45 <u>\$50</u>	
other special health needs	Skilled nursing care	30%	Х
nealth needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child D	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	2007	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	500/	
Orthodontics		50%	

Date: June 16, 2022 May 18, 2023
Summary of Benefits and Coverage

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB-only Silver Coinsurance Plan		CCSB-only Silver Copay Plan	
				Copu, I iuii	
Actuarial Value - A		71.9% <u>70.0%</u>		71.7% <u>69.7%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharma	icy	Yes, Medical/Pharm	acy
	Integrated Individual deductible Integrated Family deductible	N/A 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	\$8,600		\$8,750	
	Family Out-of-pocket maximum	\$17,200		\$17,500	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	e N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care provider's	Other practitioner office visit	\$55		\$55	
office or		ΨΟΟ		ψ00	
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%	Χ	\$300	Х
	Tier 1	\$20		\$19	
D	Tier 2	\$75	Pharmacy	\$85	Pharmacy
Drugs to treat illness	16.2	Ψίσ	deductible	φοσ	deductible
or condition	Tier 3	\$105	Pharmacy deductible	\$110	Pharmacy deductible
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharmacy
		pharmacy deductible	deductible	pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	35%	Х	35%	Х
services	Physician/surgeon fees	35%		30% 35%	
	Outpatient visit	35%		30% 35%	
	Emergency room facility fee (waived if admitted)	35%	X	30% 35%	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	35%	Χ	30% 35%	Х
attention					
	Urgent care	\$55		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	X	40% 35%	Х
Hospital stay	Physician/surgeon fee	35%	X	4 0% 35%	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$55		\$55	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	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	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
recovering or	Skilled nursing care	35%	Х	40%- 35%	Х
other special health needs	Durable medical equipment	35%		40% 35%	.,
	Hospice service Eye exam	No charge		No charge	
Child eye care	·	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2023 2024 Dental Copay	
Services	Periodontal Maintenance Services	=270		Schedule	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See-2023 2024 Dental Copay Schedule	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics				, , , , , ,	

Date: June 16	i, 2022 <u>May 18, 2023</u>		
	nefits and Coverage	CCSB-o	•
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver HDHP P	
Actuarial Value - A'	v Calculator Plan design includes a deductible?	71.7% Yes, integr	
	Integrated Individual deductible	\$ 2,700 <u>\$2,850</u> i	
	Integrated Family deductible	\$5,400 \$5,700 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>	
	Family Out-of-pocket maximum		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$2,700 <u>\$2</u> See endr	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	25%	x
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
	Tier 1	25% up to \$250 per	x
		script 25% up to \$250 per	
Drugs to treat illness	Tier 2	script	X
or condition	Tier 3	25% up to \$250 per script	X
	Tier 4	25% up to \$250 per	X
	101 -	script	,
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%	X
N I	Emergency room physician fee (waived if admitted)	0%	X
Need immediate	Medical transportation (including emergency and non-emergency)	25%	X
attention			
	Urgent care	25%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	25%	X
	Physician/surgeon fee	25%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	25%	X
behavioral health, or	VISIO		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	x
Pregnancy	Prenatal care and preconception visits	No charge	
rregilation	Home health care (cost share per visit)	25%	X
Halm	Outpatient Rehabilitation and Habilitation services	25%	X
Help recovering or	Skilled nursing care	25%	X
other special health needs	-		
	Durable medical equipment Hospice service	25% 0%	X X
	Eye exam	0% No charge	^
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	710 Glaige	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
Child Day	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

Date: June 16, 2022 <u>May 18, 2023</u>

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
ctuarial Value - A		94.9%		87.9%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/F	harmacy	Yes, Medical/Pharm	acy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$800 / \$25 <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 <u>\$2</u>	<u>,300</u>	\$6,000 <u>\$6,300</u>	
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible	N/A Member Cost	Deductible	N/A	Deductib
Medical Event	Service Type	Share	Applies	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
provider's office or	Other practitioner office visit	\$5		\$15	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5 \$6	Pharma
					deductil Pharma
Drugs to treat illness	Tier 2	\$10		\$25	deductil Pharma
or condition	Tier 3	\$15		\$45	deductil
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharma deducti
	Surgery facility fee (e.g., ASC)	10%		15% 20%	
Outpatient services	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	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention					
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	Х	25% 20%	Х
Mental	Physician/surgeon fee Mental/behavioral health and substance use disorder outpatient office	10%		25% 20%	
health, behavioral	visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	25% 20%	Х
other special health needs	Durable medical equipment	10%	•	15%	
	Hospice service				
	Eye exam	No charge		No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge No charge	
	Oral Exam	140 Glaige		140 Glaige	
	Preventive - Cleaning				
Child Dental					
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
OLUL D	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
CEI VICES	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

2023 2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: June 16, 2022 May 18, 2023

	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan	
		200%-250% FPL	-
tuarial Value - A	V Calculator	73.9% <u>74.0%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	ntal \$4,750 \$5,400 / \$30 \$150 /	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 9,500 <u>\$10,800</u> / \$60 <u>\$3</u>	<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 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>	
Health care	Other practitioner office visit	 \$45	
office or	·	_	
clinic visit	Specialist visit	\$85 <u>\$90</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Гests	X-rays and Diagnostic Imaging	\$ 90 <u>\$95</u>	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16 \$19	Pharma
		σιφοιφ	deductib
Orugs to	Tier 2	\$55	Pharma deductib
reat illness or condition	Tier 3	\$85	Pharma
			deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	20% 30%	
Outpatient services	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 mmediate	Medical transportation (including emergency and non-emergency)	\$250	
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)	30%	х
iospitai stay	Physician/surgeon fee	30%	
Viental	Mental/behavioral health and substance use disorder outpatient office	\$45 \$50	
I4h			
	visits	\$45 <u>\$50</u>	
pehavioral nealth, or	Mental/behavioral health and substance use disorder other outpatient		
pehavioral nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45 <u>\$50</u>	
pehavioral nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits	\$45 <u>\$50</u> No charge	
pehavioral nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45 <u>\$50</u>	
pehavioral nealth, or substance abuse needs Pregnancy	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits	\$45 <u>\$50</u> No charge	
pehavioral nealth, or substance abuse needs Pregnancy	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit)	\$45 <u>\$50</u> No charge \$40	x
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services	\$45 <u>\$50</u> No charge \$40 \$45 <u>\$50</u>	x
pehavioral nealth, or substance abuse needs Pregnancy Help recovering or other special	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care	\$45 <u>\$50</u> No charge \$40 \$45 <u>\$50</u> 30% 20%	х
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service	\$45 <u>\$50</u> No charge \$40 \$45 <u>\$50</u> 30% 20% No charge	X
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs Child eye	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge	x
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs Child eye	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	\$45 <u>\$50</u> No charge \$40 \$45 <u>\$50</u> 30% 20% No charge	х
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs Child eye	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge	X
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs Child eye care	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge	X
pehavioral nealth, or substance abuse needs Pregnancy Help recovering or other special nealth needs Child eye care Child Dental Diagnostic	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge	x
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs Child eye care Child Dental Diagnostic and	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs Child eye care Child Dental Diagnostic and	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
pehavioral nealth, or substance abuse needs Pregnancy Help ecovering or other special nealth needs Child eye care Child Dental Diagnostic and	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
chavioral nealth, or substance abuse needs Pregnancy Help recovering or other special nealth needs Child eye care Child Dental Diagnostic and Preventive	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	x
cehavioral nealth, or substance abuse needs Pregnancy Help recovering or other special nealth needs Child bental Diagnostic and Preventive Child Dental Basic	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
cehavioral nealth, or substance abuse needs Pregnancy Help recovering or other special nealth needs Child bental Diagnostic and Preventive Child Dental Basic	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
cehavioral nealth, or substance abuse needs Pregnancy Help recovering or other special nealth needs Child bental Diagnostic and Preventive Child Dental Basic	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
chavioral health, or substance abuse needs Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
health, behavioral behavioral behavioral behavioral behavioral substance abuse needs Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X
behavioral health, or substance abuse needs Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Mental/behavioral health and substance use disorder other outpatient items and services Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	\$45 \$50 No charge \$40 \$45 \$50 30% 20% No charge No charge No charge	X

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
Actuarial Value - A		64.7% <u>64.4%</u>		64.2% <u>64.9</u>	
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integral	
	Integrated Individual deductible Integrated Family deductible	N/A N/A		\$7,000 <u>\$7,050</u> int \$14,000 <u>\$14,100</u> ir	-
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	60	N/A	ilegraleu
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000		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
	HSA family plan: Individual deductible	N/A		\$7,000 \$7,0	50
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$65 <u>\$60</u>	After 1st three non- preventive visits	0%	X
Health care	Other practitioner office visit	\$ 65 \$ <u>60</u>	After 1st three non-	0%	×
provider's office or	Other practitioner office visit	\$60 <u>\$60</u>	preventive visits	0 78	^
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
	Tier 1	\$18 \$17	Pharmacy Deductible	0%	x
	Tion 2	40% up to \$500 per script after	Pharmacy	001	
Drugs to treat illness	Tier 2	pharmacy deductible	Deductible	0%	X
or condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 4	40% up to \$500 per script after	Pharmacy	0%	×
	1101 4	pharmacy deductible	Deductible	0 78	^
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient services	Physician/surgeon fees	40%	X	0%	X
	Outpatient visit	40%	X	0%	X
Need	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
immediate attention	Urgent care	\$ 65 <u>\$60</u>	After 1st three non- preventive visits	0%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		·		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	40% 40%	X X	0% 0%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$ 65 <u>\$60</u>	After 1st three non- preventive visits	0%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$ 65 <u>\$60</u>	×	0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	X	0%	X
Holo	Outpatient Rehabilitation and Habilitation services	\$65 \$60		0%	X
Help recovering or	Skilled nursing care	40%	X	0%	X
other special health needs	-				
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
Juil	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	. to shargo		, to shargo	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Basic Services	Periodontal Maintenance Services	20%		∠0%	
	Crowns and Casts				
	Endodontics				
Child Dental					
Major	Periodontics (other than maintenance)	50%		50%	
	Periodontics (other than maintenance) Prosthodontics	50%		50%	
Major	,	50%		50%	

Summary of	Benefits	and Co	verage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A	AV Calculator		
-ctuariai value - A	Plan design includes a deductible?	Yes.	integrated
	Integrated Individual deductible		1,450 integrated
	Integrated Family deductible	\$18,200 <u>\$1</u>	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 <u>\$9,450</u>
	Family Out-of-pocket maximum	\$18,2	00 <u>\$18,900</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
provider's	Other practitioner office visit	0%	After 1st three non- preventive visits
office or clinic visit	Specialist visit	0%	x
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	x
	Imaging (CT/PET scans, MRIs)	0%	×
	Tier 1		
	TIGHT	0%	X
Drugs to	Tier 2	0%	x
treat illness or condition	Tier 3	0%	x
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	x
Outpatient services	Physician/surgeon fees	0%	x
30, 11003	Outpatient visit	0%	x
	Emergency room facility fee (waived if admitted)	0%	x
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	0%	X
immediate attention			
	Urgent care	0%	After 1st three non- preventive visits
			preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	X
Hospital stay	delivery, mental health, and substance use)		
Mental	Physician/surgeon fee	0%	X
health,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
behavioral health, or	Martin de la contraction de la		
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	Outpatient Rehabilitation and Habilitation services	0%	×
recovering or	Skilled nursing care	0%	X
other special health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
	Eye exam	No charge	^
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam	0 /0	^
	Preventive - Cleaning		
Child Dental	Preventive - Cleaning Preventive - X-ray		
Diagnostic and		No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed		
Basic	Restorative Procedures	0%	Х
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	0%	X
	Prosthodontics		
Ohi:	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	0%	X

9.5 EHB

Date: June 16, 2022 May 18, 2023

Summary of Benefits and Coverage



	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
ctuarial Value - AV	/ Calculator	91.8% <u>91.9</u>	9%	89.8% <u>90.7</u>	" %
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum			\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
Cillic Visit	•				
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5 \$7		\$5 \$7	
Drugs to treat	Tier 2	\$15 \$16		\$15 \$16	
illness or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100 \$75	
Outpatient	Physician/surgeon fees	10%		\$25 <u>\$20</u>	
services					
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 \$225 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or	Skilled nursing care	10%		\$150 \$125 per day	
other special health needs				up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental					
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
Child Dental	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
		Not Covered		Not Covered	
Major	Periodontics (other than maintenance) Prosthodontics	Not Covered		Not Covered	
Major	Periodontics (other than maintenance)	Not Covered		Not Covered Not Covered	

2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 May 18, 2023

Date: June 16	i, 2022 <u>May 18, 2023</u>				
Summary of Ber	nefits and Coverage	CCSB-onl Platinum		CCSB-oni Platinum	•
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance		Copay Pla	
A -4:- \ /- A \	V Oslavlska	00.70/.04.0	10/	00.00/.00.4	0/
Actuarial Value - A		90.7% <u>91.2</u>	<u>'%</u>	88.8% <u>89.4</u>	<u>-%</u>
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out–of–pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care	Timary care visit to treat arringing, illness, or condition	\$15		\$20	
provider's office or	Other practitioner office visit	\$15		\$20	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
	Tier 2	\$25		\$20	
Drugs to treat illness or	2	Ψ23		Ψ20	
condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%			
services	Outpatient visit	10%		\$25 10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room hashing fee (waived if admitted)	No charge			
Need	Medical transportation (including emergency and non-emergency)	\$150		No charge \$150	
immediate	medical transportation (including emergency and not emergency)	\$150		\$150	
attention	Urgent care	\$15		\$20	
	orgeni care	φ15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100/		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
behavioral health, or					
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Holo	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
Help recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
	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	onargo		5 516190	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
,,,,,,,,,	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 May 18, 2023

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - A\	/ Calculator	91 00/		00 10/, 01 5	:0/
luariai value - A	V Carculator Plan design includes a deductible?	81.9% No		80.1% 81.5 No	1%
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$ 8,550 <u>\$8,7</u> 0	<u>00</u>	\$ 8,550 <u>\$8,7</u>	<u>'00</u>
	Family Out-of-pocket maximum	\$17,100 <u>\$17,</u> 4	<u>400</u>	\$17,100 <u>\$17</u> ,	400
	HSA family plant laditide and deductible			N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie
lealth care	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
provider's office or	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
Orugs to treat	Tier 2	\$60		\$60	
ondition	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 services	Physician/surgeon fees	20% 30%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250	
mmediate attention					
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$350 \$330 per day	
Hospital stay	delivery, mental health, and substance use)	30%		up to 5 days	
	Physician/surgeon fee	30%		No charge	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
regulaticy				_	
	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	
ivaiui needs	Durable medical equipment	20%		20%	
	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				
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 Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	1101 Govered		, tot Govereu	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

Summary of Ber	, 2022 May 18, 2023 nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		CCSB-only Gold	
S. Sost Share		Coinsurance Pla	n	Copay Plan	
Actuarial Value - A\	/ Calculator	78.9% <u>78.8%</u>		80.5% <u>80.7%</u>	
	Plan design includes a deductible?		acy	Yes, Medical/Pharr	macy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible			N/A	
0	HSA family plan: Individual deductible	N/A	l	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care provider's	Other practitioner office visit	\$25		\$35	
office or clinic visit	Specialist visit	\$50		\$55	
omno viole	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55 \$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	x
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$40	
illness or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
0.1	Surgery facility fee (e.g., ASC)	20%		\$300	X
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	20%	×	\$250	х
	Urgent care	\$25		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20% 20%	X X	\$600 per day up to 5 days	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
recovering or	Skilled nursing care	20%	×	\$300 per day up to 5 days	X
other special health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	9-		3 -	
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
33111003	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics	25.5.53			
	Oral Surgery				
Child		Not Course		Not Coursed	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan	
tuarial Value - A\	/ Calculator	71.6% <u>71.8%</u>		
tuariai value - A		Yes, Medical/Pharm	1001	
	Plan design includes a deductible? Integrated Individual deductible		iacy	
	Integrated Family deductible	N/A N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 \$5,400 / \$85 <u>\$1</u>	50 / \$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	Deductil Applie:	
	Primary care visit to treat an injury, illness, or condition	\$45 <u>\$50</u>		
Health care provider's	Other practitioner office visit	\$45 <u>\$50</u>		
office or	Considerate state	* 05 * 00		
clinic visit	Specialist visit	\$85 <u>\$90</u>		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$50		
Tests	X-rays and Diagnostic Imaging	\$95		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$16 <u>\$19</u>	Pharma deductil	
	T. 0	_	Pharma	
Drugs to treat	Tier 2	\$60	deducti	
illness or condition	Tier 3	\$90	Pharma deductil	
		20% up to \$250 per script	Pharma	
	Tier 4	after pharmacy deductible	deducti	
	Surgery facility fee (e.g., ASC)	20% 30%		
Outpatient	Physician/surgeon fees	20% 30%		
services	Outpatient visit	20% 30%		
	Emergency room facility fee (waived if admitted)	\$400 \$450		
Nasal	Emergency room physician fee (waived if admitted)	No charge		
Need immediate	Medical transportation (including emergency and non-emergency)	\$250		
attention	Urgent care	\$45 <u>\$50</u>		
	orgenicare	क्याउ क <u>ुउए</u>		
Heavital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	х	
Hospital stay	Physician/surgeon fee	30%		
Mental	Mental/behavioral health and substance use disorder outpatient office	045.050		
health, behavioral	visits	\$45 <u>\$50</u>		
health, or	Mental/behavioral health and substance use disorder other outpatient			
substance abuse needs	items and services	\$45 <u>\$50</u>		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$45		
	Outpatient Rehabilitation and Habilitation services			
Help recovering or	· ·	\$45 <u>\$50</u>		
other special	Skilled nursing care	30%	X	
health needs	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
	Preventive - Cleaning			
Child Dental	Preventive - X-ray			
Diagnostic and	·	Not Covered		
Preventive	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services	5510104		
	Crowns and Casts			
Child Daniel	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			

2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 May 18, 2023 Summary of Benefits and Coverage CCSB-only CCSB-only Silver Member Cost Share amounts describe the Enrollee's out of pocket costs Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 71.9% <u>70.0%</u> 71.7% <u>69.7%</u> Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy 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 \$8,600 \$8,750 Family Out-of-pocket maximum \$17.200 \$17,500 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Medical Service Type **Member Cost Share Member Cost Share** Event Primary care visit to treat an injury, illness, or condition \$55 \$55 Health care Other practitioner office visit \$55 \$55 provider's office or Specialist visit clinic visit \$90 \$90 Preventive care/ screening/ immunization No charge No charge \$55 Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) 35% Х \$300 Tier 1 \$19 \$20 Pharmacy Pharmacy Tier 2 \$75 \$85 Drugs to treat deductible deductible Pharmacy Pharmacv condition Tier 3 \$105 \$110 deductible deductible Pharmacy Pharmacy 30% up to \$250 per script afte 30% up to \$250 per script after Tier 4 pharmacy deductible pharmacy deductible deductible deductible Surgery facility fee (e.g., ASC) 35% Х 35% Х Outpatient Physician/surgeon fees 30% 35% 35% Outpatient visit 35% 30% 35% Emergency room facility fee (waived if admitted) 30% 35% 35% Emergency room physician fee (waived if admitted) No charge No charge Need Medical transportation (including emergency and non-emergency) 30% 35% 35% Х Х immediate \$55 Urgent care \$55 Facility fee (e.g. hospital room) for inpatient stay (including labor and 40% 35% Х delivery, mental health, and substance use) Hospital stay 40% 35% Mental Mental/behavioral health and substance use disorder outpatient office health, behavioral health, or \$55 \$55 visits Mental/behavioral health and substance use disorder other outpatient substance \$55 abuse needs No charge Pregnancy No charge Home health care (cost share per visit) 35% \$45 Outpatient Rehabilitation and Habilitation services \$55 \$55 Help recovering or 40% 35% Skilled nursing care 35% Х Х other special health needs Durable medical equipment 40% 35% Hospice service No charge No charge Eye exam No charge No charge Child eye 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 Not Covered Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed **Child Dental** Not Covered Not Covered Periodontal Maintenance Services Services Crowns and Casts Endodontics **Child Dental** Periodontics (other than maintenance) Not Covered Not Covered Major Services Prosthodontics

Not Covered

Not Covered

Oral Surgery

Medically necessary orthodontics

9.5 EHB Date: June 16, 2022 May 18, 2023 CCSB-only Summary of Benefits and Coverage Silver HDHP Plan Member Cost Share amounts describe the Enrollee's out of pocket costs Actuarial Value - AV Calculator 71.7% Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2,700 <u>\$2,850</u> integrated Integrated Family deductible \$5,400 \$5,700 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 \$7,500 Family Out-of-pocket maximum \$14,400 <u>\$15,000</u> HSA plan: Self-only coverage deductible \$2,700 <u>\$2,850</u> HSA family plan: Individual deductible See endnote Common Medical Service Type Member Cost Share Deductible Applie Event Primary care visit to treat an injury, illness, or condition 25% Health care provider's 25% Other practitioner office visit Х office or Specialist visit clinic visit 25% Preventive care/ screening/ immunization No charge Tests X-rays and Diagnostic Imaging Х Imaging (CT/PET scans, MRIs) 25% Х 25% up to \$250 per Tier 1 Х 25% up to \$250 per Tier 2 Drugs to treat script 25% up to \$250 per condition Tier 3 Х script 25% up to \$250 per Tier 4 script Surgery facility fee (e.g., ASC) 25% Х Outpatient Physician/surgeon fees 25% Х Outpatient visit 25% Х Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) 0% Х Medical transportation (including emergency and non-emergency) 25% Х immediate Urgent care 25% Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Hospital stay Mental Mental/behavioral health and substance use disorder outpatient office 25% health. visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance abuse needs 25% No charge Pregnancy Home health care (cost share per visit) 25% Х Outpatient Rehabilitation and Habilitation services 25% Х Help recovering or Skilled nursing care 25% Х other special health needs Durable medical equipment 25% Eye exam No charge Child eye 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 Not Covered Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Not Covered Services Periodontal Maintenance Services Crowns and Casts Endodontics **Child Dental** Major Services Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery

Medically necessary orthodontics

Not Covered

Summary	ν of	Benefits	and	Coverage
Summan	<i>,</i> 01	Denenio	anu	Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPL	
Actuarial Value - A	V Calculator	94.9%	6	87.9%	
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$800 / \$25 <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 <u>\$2</u>	<u>2,300</u>	\$ 6,000 \$ <u>6,300</u>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization			·	
	·	No charge		No charge	
_ ,	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5 \$6	Pharmacy deductible
	Tier 2	¢40		\$25	Pharmacy
Drugs to treat illness or	Her Z	\$10		\$25	deductible
condition	Tier 3	\$15		\$45	Pharmacy deductible
	-	10% up to \$150 per			Pharmacy
	Tier 4	script		15% up to \$150 per script	deductible
	Surgery facility fee (e.g., ASC)	10%		15% 20%	
Outpatient services	Physician/surgeon fees	10%		15% 20%	
361 11663	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	Medical transportation (including emergency and non-emergency)	\$30		\$75	
attention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	10%	Х	25% 20%	X
	Physician/surgeon fee	10%		25% 20%	
Mental	Mental/behavioral health and substance use disorder outpatient office	A 5		045	
health, behavioral	visits	\$5		\$15	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Holo	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or				25% 20%	
other special health needs	Skilled nursing care	10%	X		X
nearth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	·	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	5515154			
	Crowns and Casts				
OLUL 5	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 May 18, 2023

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPI	L
		20070 20070111	=
ctuarial Value - A\		73.9% 74.0%	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Family deductible	N/A N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 <u>\$5,400</u> / \$30 <u>\$1</u>	150 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 9,500 \$10,800 / \$60 \$	
	Individual Out-of-pocket maximum	\$7,250 \$7,550	<u>σσσ</u> / ψσ
	Family Out-of-pocket maximum	\$14,500 <u>\$15,100</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 provider's	Other practitioner office visit	\$45 <u>\$50</u>	
office or clinic visit	Specialist visit	\$85 \$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$90 \$95	
	Imaging (CT/PET scans, MRIs)	\$325	
			Pharma
	Tier 1	\$16 <u>\$19</u>	deductik
Drugs to treat illness or condition	Tier 2	\$55	Pharma deductik
	Tier 3	\$85	Pharma deductil
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductil
	Surgery facility fee (e.g., ASC)	20% 30%	
Outpatient services	Physician/surgeon fees	20% 30%	
SCIVICOS	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 \$50	
Hespital atou	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	x
Hospital stay	Physician/surgeon fee	30%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$45 <u>\$50</u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45 <u>\$50</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$45	
recovering or	Skilled nursing care	30%	x
other special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	1101 0070100	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

Summary	of Bene	efits and	l Coverage

ember Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
atuarial Value - A	/ Coloulator	04.70/.04.40/		64.00/.04.0	0/-
ctuarial Value - A\		64.7% <u>64.4%</u>		64.2% <u>64.9</u>	
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integrat	
	Integrated Individual deductible	N/A		\$7,000 <u>\$7,050</u> int	-
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$6.300 / \$500 / \$	0.4	\$14,000 <u>\$14,100</u> ir N/A	negrated
		\$6,300 / \$500 / \$ \$12,600 / \$1,000			
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 / \$8,200 \$9,100		N/A \$7,000 \$7,0	50
	Individual Out-of-pocket maximum	\$16,400 \$18,20		\$14,000 \$14,	
	Family Out-of-pocket maximum	\$10,400 \$18,20 N/A	O	\$7,000 \$7,0	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		\$7,000 \$7,0 \$7,000 \$7,0	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc
Event			After 1st three non-		Appl
Health care	Primary care visit to treat an injury, illness, or condition	\$65 \$60	preventive visits After 1st three non-	0%	X
provider's office or	Other practitioner office visit	\$65 <u>\$60</u>	preventive visits	0%	X
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	×
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge	
	Laboratory Tests	\$40		0%	Х
ests	X-rays and Diagnostic Imaging	40%	×	0%	×
	Imaging (CT/PET scans, MRIs)	40%	X	0%	, ,
	Tier 1	\$18 \$17	Pharmacy Deductible	0%	>
rugs to treat	Tier 2	40% up to \$500 per script after	Pharmacy	0%	\
Iness or		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy		
ondition	Tier 3	pharmacy deductible	Deductible	0%	>
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	>
_	Surgery facility fee (e.g., ASC)	40%	×	0%)
Outpatient					
ervices	Physician/surgeon fees	40%	X	0%	>
	Outpatient visit	40%	X	0%	>
	Emergency room facility fee (waived if admitted)	40%	X	0%	>
	Emergency room physician fee (waived if admitted)	No charge		0%	>
leed mmediate ittention	Medical transportation (including emergency and non-emergency)	40%	X	0%)
	Urgent care	\$ 65 <u>\$60</u>	After 1st three non- preventive visits	0%	>
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	×	0%	×
Hospital stay	Physician/surgeon fee	40%	×	0%)
/lental	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-		>
nealth, behavioral nealth, or	visits	\$65 <u>\$60</u>	preventive visits	0%	,
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65 <u>\$60</u>	¥	0%	>
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	X	0%)
lelp	Outpatient Rehabilitation and Habilitation services	\$65 <u>\$60</u>		0%	>
ecovering or	Skilled nursing care	40%	×	0%	>
ther special ealth needs	Durable medical equipment	40%	X	0%	,
			^		
	Hospice service	No charge		0%	>
child eye are	Eye exam	No charge		No charge	
uit	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
hild D	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	NI-LO.		N-+ O	
nd	Sealants per Tooth	Not Covered		Not Covered	
reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
Child Dental	I		1	I .	
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major	Periodontics (other than maintenance) Prosthodontics	Not Covered		Not Covered	
Child Dental Major Services	·	Not Covered		Not Covered	

ember Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan
tuarial Value - A\	/ Calculator Plan design includes a deductible?	Yes	integrated
	Integrated Individual deductible		9,450 integrated
	Integrated Family deductible		18,900 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 <u>\$9,450</u>
	Family Out-of-pocket maximum	\$18,2	200 <u>\$18,900</u>
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Appl
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three r
Health care provider's	Other practitioner office visit	0%	After 1st three r
office or	·	0,0	preventive vis
clinic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	x
		U /U	
Drugs to treat	Tier 2	0%	X
illness or condition	Tier 3	0%	X
	Tier 4	0%	×
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	0%	X
attention	Urgent care	0%	After 1st three r
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X
Hospital stay	Physician/surgeon fee	0%	Х
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three r preventive vis
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	×
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or		0%	×
other special health needs	Skilled nursing care		
nountil noodo	Durable medical equipment	0%	X
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	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			
Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		

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.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 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 Where indicated, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, and/or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 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.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2023 2024 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, Podiatrists, 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
	Any other drugs recommended by the plan's
	pharmaceutical and therapeutics (P&T) committee based on
	drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based
	on drug safety, efficacy and cost or;
	Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
4	Drugs that are biologics and drugs that the Food and
	Drug Administration (FDA) or drug manufacturer requires to
	be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or
	clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than
	six hundred dollars (\$600) net of rebates for a one-month
	supply.

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

24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete

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