## Covered California 2023 2024 Patient-Centered Benefit Plan Designs<sup>1</sup>

# Final Board-approved Originally Approved May 18, 2023 June 16, 2022 Revised July 20, 2023

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

Date: June 16, 2022 July 20, 2023

Summary of Benefits and Coverage

Prosthodontics Oral Surgery

Medically necessary orthodontics

Child Orthodo



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

50%

\$1,000

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	- -	CCSB-onl Platinum Copay Pla	
tuarial Value - A		<del>90.7%</del> <u>91.2</u>	<u>!%</u>	<del>88.8%</del> <u>89.4</u>	<u>.%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$0 / \$0 / \$	0	\$0 \$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$4,500	•	\$4,500	•
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appl
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
lealth care provider's	Other practitioner office visit	\$15		\$20	
office or linic visit	Specialist visit	\$30		\$30	
anne visit					
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
	Tier 2	\$25		\$20	
Drugs to reat illness					
or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient ervices	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	
leed	Medical transportation (including emergency and non-emergency)	\$150		\$150	
mmediate					
	Urgent care	\$15		\$20	
lospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
iospital stay	Physician/surgeon fee	10%		No charge	
lental	Mental/behavioral health and substance use disorder outpatient office				
ealth, behavioral bealth, or	visits	\$15		\$20	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
ecovering or	Skilled nursing care	10%		\$150 per day up to	
other special lealth needs	Durable medical equipment	10%		5 days 10%	
	Hospice service				
	Eve exam	No charge		No charge	
Child eye are		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			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2023 2024	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child					

50%

\$1,000

Child Orthodontics

Medically necessary orthodontics

10.0 EHB

Crowns and Casts

Prosthodontics Oral Surgery

Periodontics (other than maintenance)

Medically necessary orthodontics

Child Dental

Major Services

Child

Date: June 16, 2022 July 20, 2023

Summary of Benefits and Coverage Individual-only Gold Individual-only Gold Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 81.9% <del>80.1%</del> <u>81.5%</u> Plan design includes a deductible? No No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Individual Out-of-pocket maximum <del>\$8,550</del> <u>\$8,700</u> Family Out-of-pocket maximum <del>\$17,100</del> <u>\$17,400</u> HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Commor Member Cost Member Cost Deductible Applies Deductible Applies Service Type Medical Sha Sha Event Primary care visit to treat an injury, illness, or condition \$35 \$35 Health care provider's Other practitioner office visit \$35 \$35 office or clinic visit Specialist visit \$65 \$65 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$40 \$40 Tests X-rays and Diagnostic Imaging \$75 \$75 Imaging (CT/PET scans, MRIs) 25% \$75 Tier 1 \$15 \$15 Tier 2 \$60 \$60 Drugs to treat illnes or condition Tier 3 \$85 \$85 20% up to \$250 per 20% up to \$250 per Tier 4 script script Surgery facility fee (e.g., ASC) <del>20%</del> 30% <del>\$150</del> \$130 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 immediate attention Urgent care \$35 \$35 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  $% \label{eq:starses}$ \$350 \$330 per day 30% Hospital stay up to 5 days 30% No charge Physician/surgeon fee Mental Mental/behavioral health and substance use disorder outpatient office \$35 \$35 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient substance \$35 \$35 items and services abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 20% \$30 Outpatient Rehabilitation and Habilitation services \$35 \$35 Help recovering or \$150 per day up to Skilled nursing care 30% other special health needs 5 days Durable medical equipment 20% 20% Hospice service No charge No charge No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge No charge and Preventive Sealants per Tooth **Topical Fluoride Application** Space Maintainers - Fixed See-<del>2023</del> 2024 Dental Copay Child Dental Restorative Procedures 20% Basic Services Periodontal Maintenance Services Schedule

See 2023 2024

Dental Copay Schedule

\$1,000

50%

50%

# 2023 2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: June 16, 2022 July 20, 2023

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Pla	0	CCSB-only Gold Conay Plan	
		Coinsurance Pla	•	Copay Plan	
tuarial Value - A	V Calculator	<del>78.9%</del>		<del>80.5%</del> <u>80.7%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$350 / \$0 / \$0		N/A \$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$300 / \$0 / \$0 \$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care provider's	Other practitioner office visit	\$25		\$35	
office or					
clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$50		\$40	
treat illness					
or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	х	\$250	х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	х	\$250	х
immediate attention					
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	20%	Х	\$600 per day up to 5 days	Х
	Physician/surgeon fee	20%	х	No charge	
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	
	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
Help recovering or					
other special health needs	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х
	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				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	. 10 0.10.90			
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2023 2024 Dental Copay Schedule	
Services	Periodontal Maintenance Services			Constants	
	Crowns and Casts				
Child Dental	Endodontics			See 2023 2024 Dental Correct	
Major Services	Periodontics (other than maintenance)	50%		See 2023 2024 Dental Copay Schedule	
20111003	Prosthodontics				
	Oral Surgery				
Child		50%		\$1,000	

### 2023 2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: June 16, 2022 July 20, 2023

Summary of Benefits and Coverage

mber Cost Share amounts describe the Enrollee's out of pocket costs.		Individual-only Silver Plan		
tuarial Value - A'	V Calculator	<del>71.6%</del>		
	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	<del>\$9,500</del>	<u>300</u> / \$0	
	Individual Out–of–pocket maximum	<del>\$8,750</del>		
	Family Out-of-pocket maximum	<del>\$17,500</del> <u>\$18,200</u>	<u>)</u>	
	HSA plan: Self-only coverage deductible	N/A N/A		
Common Medical	HSA family plan: Individual deductible Service Type	Member Cost Share	Deductib	
Event	Primary care visit to treat an injury, illness, or condition	\$45 <u>\$50</u>	Applies	
Health care		<del>\$43</del> <u>\$30</u>		
provider's	Other practitioner office visit	\$45 <u>\$50</u>		
clinic visit	Specialist visit	<del>\$85</del>		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$50		
Tests	X-rays and Diagnostic Imaging	\$95		
	Imaging (CT/PET scans, MRIs)	\$325		
			Pharma	
	Tier 1	<del>\$16</del>	deductik	
Drugs to	Tier 2	\$60	Pharma deductik	
reat illness or condition	Tier 3	\$90	Pharma	
			deductik	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductit	
	Surgery facility fee (e.g., ASC)	<del>20%-</del> 30%		
Outpatient services	Physician/surgeon fees	<del>20%</del> 30%		
services	Outpatient visit	<del>20%</del> 30%		
	Emergency room facility fee (waived if admitted)	<del>\$400</del> \$450		
	Emergency room physician fee (waived if admitted)	No charge		
Need	Medical transportation (including emergency and non-emergency)	\$250		
immediate		ψ230		
attention		<b>A</b> 15 <b>A</b> 50		
	Urgent care	<del>\$45</del>		
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and			
Hospital stay	delivery, mental health, and substance use)	30%	Х	
	Physician/surgeon fee	30%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	<u>\$45                                    </u>		
behavioral	visits	<del>940</del>		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	<del>\$45</del>		
abuse needs	items and services	\$40 <u>800</u>		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$45		
Help	Outpatient Rehabilitation and Habilitation services	\$4 <del>5</del>		
recovering or other special	Skilled nursing care	30%	x	
health needs	Durable medical equipment	20%		
	Hospice service	No charge		
	Eye exam	-		
Child eye care		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray	No charge		
and Preventive	Sealants per Tooth	-		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	20%		
Services	Periodontal Maintenance Services	2070		
	Crowns and Casts			
	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	50%		
Services	Prosthodontics			
	Oral Surgery			

# 2023 2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: June 16, 2022 July 20, 2023

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plan		CCSB-only Silver Copay Plan	
tuarial Value - A	V Calculator	<del>71.9%</del> <u>70.0%</u>		<del>71.7%</del> <u>69.7%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharma	acv	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 HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common			Daductikla		Daducti
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applie
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care provider's	Other practitioner office visit	\$55		\$55	
office or clinic visit	Creationist	<b>\$</b> 00		<b>\$</b> 00	
clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
lests .	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	х	\$300	Х
	Tier 1	\$20		\$19	
	Tier 2	\$75	Pharmacy	\$85	Pharm
Drugs to reat illness		¢10	deductible	COQ	deduct
or condition	Tier 3	\$105	Pharmacy deductible	\$110	Pharm deduct
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharm deduct
	Surgery facility fee (e.g., ASC)	35%	х	35%	Х
Outpatient services	Physician/surgeon fees	35%		<del>30%</del> 35%	
	Outpatient visit	35%		<del>30%</del> 35%	
	Emergency room facility fee (waived if admitted)	35%	х	<del>30%</del> 35%	х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	35%	х	<del>30%</del> 35%	х
immediate attention			~		X
	Urgent care	\$55		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	х	<del>40%</del> 35%	х
Hospital stay	Physician/surgeon fee	35%	x	4 <del>0%</del> 35%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$55		\$55	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
egnancy	Home health care (cost share per visit)	No charge 35%		No charge \$45	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
other special	Skilled nursing care	35%	Х	<del>40%-</del> 35%	Х
health needs	Durable medical equipment	35%		<del>40%</del> 35%	
	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				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2023 2024 Dental Copay Schedule	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See-2023 2024 Dental Copay Schedule	
Services	Prosthodontics			Concuuit	
	Oral Surgery				
	orarourgery				

Prosthodontics Oral Surgery

Medically necessary orthodontics

50%

Child Orthodontics

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	•
tuarial Value - A	V/ Calculator	71.7%	
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$2,700 <u>\$2,850</u> i	
	Integrated Family deductible	<del>\$5,400</del> <u>\$5,700</u> i	-
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out–of–pocket maximum	<del>\$7,200</del>	,500
	Family Out-of-pocket maximum	<del>\$14,400</del>	<u>5.000</u>
	HSA plan: Self-only coverage deductible		
Common Medical	HSA family plan: Individual deductible Service Type	See endr	
Event	Primary care visit to treat an injury, illness, or condition	25%	x
Health care provider's	Other practitioner office visit	25%	х
office or clinic visit	Specialist visit	25%	x
cinic visit			^
	Preventive care/ screening/ immunization	No charge	V
<b>T</b>	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	х
	Tier 1	25% up to \$250 per script	x
Drugs to	Tier 2	25% up to \$250 per script	х
treat illness or condition	Tier 3	25% up to \$250 per script	x
	Tier 4	25% up to \$250 per script	х
	Surgery facility fee (e.g., ASC)	25%	х
Outpatient	Physician/surgeon fees	25%	x
services	Outpatient visit	25%	x
	Emergency room facility fee (waived if admitted)	25%	x
	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
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	х
	Physician/surgeon fee	25%	х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	25%	x
health, or 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	
	Home health care (cost share per visit)	25%	х
Help	Outpatient Rehabilitation and Habilitation services	25%	x
recovering or	Skilled nursing care	25%	x
other special health needs	Durable medical equipment	25%	x
		0%	x
	Hospice service		^
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	2070	
	Crowns and Casts		
Child Dental	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		

Date: June 16, 2022 July 20, 2023

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		<b>Silver Plan</b> 150%-200% FPI	L
uarial Value - A'	V Calculator	94.9%		87.9%	
uariai value - A	Plan design includes a deductible?	Yes, Medical/F		Yes, Medical/Pharm	
	Integrated Individual deductible	N/A	namacy	N/A	lacy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$800 / <u>\$25 \$50</u> / \$	\$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$1,600 / <del>\$50</del> <u>\$100</u> /	
	Individual Out-of-pocket maximum	\$900 <u>\$1,</u>		\$3,000 \$3,150	ψū
	Family Out-of-pocket maximum	\$1,800 <u>\$2</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	Deductib Applies
Lvent	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
JIIIIC VISIC					
_	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
ests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		<del>\$5</del> \$6	Pharma
					deductil Pharma
Drugs to	Tier 2	\$10		\$25	deductil
reat illness or condition	Tier 3	\$15		\$45	Pharma
					deductil
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharma deducti
	Surgery facility fee (e.g., ASC)	10%		<del>15%</del> 20%	
Outpatient	Physician/surgeon fees	10%		<del>15%</del> 20%	
ervices					
	Outpatient visit	10%		<del>15%</del> 20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	х	<del>25%</del> 20%	x
lospital stay	delivery, mental health, and substance use)		~	<del>25%</del> 20%	
fantel	Physician/surgeon fee	10%		2078	
lental nealth, nehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
nealth, 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	
	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
lelp ecovering or					
ther special	Skilled nursing care	10%	Х	<del>25%</del> 20%	X
ealth needs	Durable medical equipment	10%		15%	
	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				
hild Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
nd Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				

#### 2023 2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: June 16, 2022 July 20, 2023

emper Cost Shai	e amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	-
ctuarial Value -	AV Calculator	<del>73.9%</del>	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 <u>\$5,400</u> / \$30 <u>\$1</u>	<u>50</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$9,500</del>	<u>300</u> / \$0
	Individual Out–of–pocket maximum	<del>\$7,250</del> <u>\$7,550</u>	
	Family Out-of-pocket maximum	<del>\$14,500</del> <u>\$15,100</u>	<u>)</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common			Deductib
Medical Event	Service Type	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$45 <u>\$50</u>	
provider's office or	Other practitioner office visit	\$45 <u>\$50</u>	
clinic visit	Specialist visit	<del>\$85</del>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	<del>\$90</del>	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	<del>\$16</del> \$19	Pharma
		<del>φτο</del> φι <del>ο</del>	deductib
Drugs to	Tier 2	\$55	Pharma deductib
treat 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)	<del>20%</del> 30%	
Outpatient services	Physician/surgeon fees	<del>20%</del> 30%	
361 11003	Outpatient visit	<del>20%</del> 30%	
	Emergency room facility fee (waived if admitted)	<del>\$400</del> \$450	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate	······································	φ200	
attention			
	Urgent care	<del>\$45</del>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery montal health, and substance use)	30%	Х
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	<u>\$45                                    </u>	
behavioral	visits	¢.0 <u>000</u>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	<u>\$45 \$50</u>	
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	<del>\$45</del>	
other special		30%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	20%	
Services	Periodontal Maintenance Services Crowns and Casts		
	Endodontics		
		E00/	
Child Dental Major Services	Periodontics (other than maintenance)	50%	
	Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%	

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

	ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
ProbabilityYurng NetworkYurng NetworkYurng NetworkYurng 	tuarial Value - A		64.7% 64.4%		64.2% 64.9	%
Intragent productionInterface of the second production of the second pr				nacy		
InteractionInteracti		-		nacy	_	
Initial distant MUT myourd Mutan Person (2014)MUTAN IMUTAN IIntervalues Sectors (2014)MUTAN IMUTAN IMUTAN IMUTAN IIntervalues Sectors (2014)MUTAN IMU		-				•
Isample set in the set in t				50		nogratou
Interfact (all out) social many many basis)URL (UP out) (UP						
TransbTransbCharacterC						50
Italians biolog         NA         Second Sec						
Under the sectorDescriptionDesc				•		
National Image: section typeNetwork of the section typeNetwork o						
cont         printary care with to term of play, lifes, or outdoor         offer the proof prove three with offer with the proof proof the proof the with the proof proof the proof the with the proof proof the proof	Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applie
Interfactor         Section of the back and the problem of t	Event	Primary care visit to treat an injury, illness, or condition	\$ <del>65</del>		0%	
Answer         Appendix with the a		Other practitioner office visit	\$65 \$60		0%	x
Mathematicant waterMathematicantMathematicantMachangeMachangeMachangeLaberstey TestAddition of the state of the			<del>903</del> <u>900</u>	· ·	0%	^
Laboratory Tradit         Laboratory Tradit         Notes         Notes         Notes         Notes         Notes           Terra         Tirr 1         Tirr 2         10% (M1)         10% (M1)         Notes	clinic visit	Specialist visit	\$95		0%	Х
Press     Name of Dispussion longuing (CFPET stares, MNs)     <		Preventive care/ screening/ immunization	No charge		No charge	
Image (CTPET South and any S		Laboratory Tests	\$40		0%	х
Image (CTPET South and any S	Tests	X-rays and Diagnostic Imaging	40%	×	0%	x
For 1         Status         Partmany Deckade         Order         No.           The 2         40% to 5500 per script aller phromesy decision         Plasmany Phromesy decision         Order         No.           The 3         40% to 5500 per script aller phromesy decision         Plasmany Phromesy decision         Order         No.           Comparison         Auge to 5500 per script aller phromesy decision         Plasmany Phromesy decision         Order         No.           Comparison comparison         Auge to 5500 per script aller phromesy decision         No.						
Introduction         Introduction         Addition to SOO per use plat interplation of the plate source plate interplation of the plate source plate interplation of the plate source plate interplate in			40%	^	0%	X
Instrument         Instrum		Tier 1	<del>\$18</del> \$17	Pharmacy Deductible	0%	Х
Interesting is condition is condit is condit is condition is conditi is condition is condition is c		Tier 2			0%	Y
The 3     All A basis but pet the interpand in the interpand in the interpand in the basis but pet the interpand in the interpand in the interpand in the basis but pet the interpand in the interpand					070	^
Image: state in the state i		Tier 3			0%	х
Intera     Optimized parameters     Opt						
Output         Physician'surgeones         Adv, solution         X         0,%         X           Verticing         Quaptient visit         0.0000         0.0000         0.0000         0.0000         0.0000         0.0000         0.0000         0.0000         0.000000000         0.000000000         0.		Tier 4			0%	Х
Production total         Production total         Control         Contro         Control         Contro		Surgery facility fee (e.g., ASC)	40%	х	0%	х
Beneficient viat         Outpatient viat         Outpatien		Physician/surgeon fees	40%	×	0%	x
Energency noom hacility fee (waiwed if admitted)         44%         X         0%         X           Energency noom hysician fee (waiwed if admitted)         No chargo         0%         X         0%         X           Medical transportation (including energency and non-energency)         40%         X         0%         X           Integer and         Solid program (including energency and non-energency)         40%         X         0%         X           Integer and         Solid program (including energency and non-energency)         40%         X         0%         X           Integer and         Solid program (including energency and non-energency)         40%         X         0%         X           Integer and         Solid program (including energency and non-energency)         40%         X         0%         X           Integer and         Solid program (including energency and non-energency)         40%         X         0%         X           Integer and solid program (including energency and non-energency)         Integer and solid program (including energency and non-energency)         Aler set program (including energency and non-energency)         Aler set program (including energency and non-energency)         No           Integer and solid program (including energency and non-energency and energency and energency and energency and energency and energency and energency	services					
Seed and services         Emergency room physician fee (waived if admitted)         No charge         A         0.95         X           Weed all ransportation (including emergency and non-emergency)         40%         X         0.95         X           Ugent care         See 550         After 151 three non- preventive visits         0.95         X         0.95         X           Height and testistication         See 550         After 151 three non- preventive visits         0.95         X         0.95         X           Height and testistication         See 550         After 151 three non- preventive visits         0.95         X         0.95         X           Metratal-backwical health and substance use disorder outpatient three and services         See 550         X         0.95         X           Metratal-backwical health and substance use disorder outpatient three and services         See 550         X         0.95         X           Metratal-backwical health and substance use disorder outpatient three and services         See 550         X         0.95         X           Metratal-backwical health and substance use disorder outpatient three and services         See 550         X         0.95         X           Metratal-backwical health and substance use disorder outpatient three and services         See 550         X         0.95		•				
Needed immediate immedi		Emergency room facility fee (waived if admitted)	40%	X	0%	Х
Internet of a boot of the boot		Emergency room physician fee (waived if admitted)	No charge		0%	Х
time     instant     former and mean mean mean mean mean mean mean mean		Medical transportation (including emergency and non-emergency)	40%	x	0%	х
Urgent take         Drive						
Hospital state physicar/surgeon fee     Adv     Adv     Adv     Adv     Adv       Physicar/surgeon fee     40%     X     0%     X       Advertailbehavioral health and substance use disorder outpatient office behavioral health, or usis     Refe 500     Alter-1st Horonom- preventive visis     0%     X       Pregnary     Prenatal care and preconception visits     0No charge     X     0%     X       Pregnary     Prenatal care and preconception visits     0No charge     0%     X       Advertailbehavioral health and substance use disorder outpatient office abuse needs     0No charge     No charge     No charge     No charge     No charge     X       Prenatal care and preconception visits     0No charge     00%     X     0%     X       Outpatient Rehabilitation and Habilitation services     040%     X     0%     X       Outpatient Rehabilitation and Habilitation services     0No charge     0%     X     0%       Outpatient Rehabilitation and Habilitation services     0No charge     No charge     0%     X       Duaba medical equipment     0No charge     No charge     No charge     No charge       Tail of glasses per year (or contact lenses in lieu of glasses)     No charge     No charge     No charge       Preventive - Cleaning     Nocharge     No charge		Urgent care	<del>\$65</del>		0%	х
Hospital state physicar/surgeon fee     Adv     Adv     Adv     Adv     Adv       Physicar/surgeon fee     40%     X     0%     X       Advertailbehavioral health and substance use disorder outpatient office behavioral health, or usis     Refe 500     Alter-1st Horonom- preventive visis     0%     X       Pregnary     Prenatal care and preconception visits     0No charge     X     0%     X       Pregnary     Prenatal care and preconception visits     0No charge     0%     X       Advertailbehavioral health and substance use disorder outpatient office abuse needs     0No charge     No charge     No charge     No charge     No charge     X       Prenatal care and preconception visits     0No charge     00%     X     0%     X       Outpatient Rehabilitation and Habilitation services     040%     X     0%     X       Outpatient Rehabilitation and Habilitation services     0No charge     0%     X     0%       Outpatient Rehabilitation and Habilitation services     0No charge     No charge     0%     X       Duaba medical equipment     0No charge     No charge     No charge     No charge       Tail of glasses per year (or contact lenses in lieu of glasses)     No charge     No charge     No charge       Preventive - Cleaning     Nocharge     No charge	_	Facility fee (e.g. hospital room) for inpatient stay (including labor and				×.
Matrial beaktion	Hospital stay	delivery, mental health, and substance use)	40%	X	0%	X
beaktion beaktio		Physician/surgeon fee	40%	х	0%	Х
behavior substance         interference         predutive resists         predutive resists         predutive resists           behavior substance         Mertal/behavioral health and substance use disorder other outpatient tiems and services         See 560         X         0% charge         X           Pregnancy         Prenatal care and preconception visits         More health care (cost share per visit)         40%         X         0% charge         X           Hung, feerence         Guidal nursing care         40%         X         0%         X           billed nursing care         More health care (cost share per visit)         40%         X         0%         X           Child open edical equipment         40%         X         0%         X         0%         X           Dirable medical equipment         40%         X         0%         X         0%         X           Child open Earce         Preventive - Cleaning         No charge         No c		Mental/behavioral health and substance use disorder outpatient office		After 1st three non-	00/	v
Substance         Merial behavioral heath and substance use disorder other outpatient items and services         See SED         X         0%         X           Pregnancy         Frental care and preconception visits         No charge         No charge         No charge         No charge         No charge         X           Heap Pregnancy         Frental care (cots share per visit)         40%         X         0%         X           Outpatient Rehabilitation and Habilitation services         666 560         X         0%         X           Stilled nursing care         40%         X         0%         X           Durable medical equipment         40%         X         0%         X           theath needs         Init of glasses per year (or contact lenses in lieu of glasses)         No charge         No charge<		visits	<del>403</del> 700	preventive visits	0%	^
Pregnancy       Prenatical care and preconception visits       No charge       No charge       No charge         Heip precovering of the sabilitation and Habilitation services       3666 \$500       X       0,0%       X         Visite medical equipment       40%       X       0,0%       X         Durable medical equipment       40%       X       0,0%       X         Heip covering       700 are the sabilitation and Habilitation services       No charge       0,0%       X         Child energical equipment       No charge       0,0%       X       X         Heip covering       No charge       0,0%       X       X         The preventive - cleaning       No charge	health, or substance		<del>\$65</del>	×	0%	х
Heip covering of other special beath need     Outpatient Rehabilitation and Habilitation services     S665 \$00     0%     X       Skilled nursing care     A0%     X     0%     X       Durable medical equipment     40%     X     0%     X       Hospice service     No charge     0%     X       Preventive of glasses per year (or contact lenses in lieu of glasses)     No charge     No charge     No charge       Oral Exam     No charge     No charge     No charge     No charge       Preventive - Cleaning     Preventive - Cleaning     No charge     No charge     No charge       Preventive - Cleaning     Preventive - Cleaning     No charge     No charge     No charge       Preventive - Cleaning     Preventive - Cleaning     No charge     No charge     No charge       State Addition - Array     Sead Maintainers - Fixed     Restorative Procedures     20%     20%       Space Maintainers - Fixed     20%     20%     20%     20%       Child Dentis     Crowns and Casts     Findodontics     50%     50%     50%     50%       Services     Course and Casts     Findodontics     50%     50%     50%     50%     50%	_		No charge		No charge	
Image: Problem Specific Spectra Spect		Home health care (cost share per visit)	-	x		x
Skilled nursing care       A40%       X       0%       X         Durable medical equipment       A40%       X       0%       X         Hospice service       No charge       0%       X         Child eque       Perventice       No charge       0%       X         1 pair of glasses per year (or contact lenses in lieu of glasses)       No charge       No charge       No charge         Child eque       Oral Exam       No charge       No charge       No charge       No charge         Child Dentify       Preventive - Cleaning       No charge       No charge       No charge       No charge       Preventive - Cleaning       No charge       Preventive - Cleaning       No charge       Preventive - Cleaning						
other special health need/ health need/						
Child eye       Induce inducated equipment       40%       X       0%       X         Hospice service       No charge       0%       X         Child eye       Eye exam       No charge       No charge       No charge       No charge         1 pair of glasses per year (or contact lenses in lieu of glasses)       No charge       No charge <td< td=""><td>other special</td><td>Skilled nursing care</td><td>40%</td><td>X</td><td>0%</td><td>Х</td></td<>	other special	Skilled nursing care	40%	X	0%	Х
Child eye care       Eye exam       No charge       No charge       No charge         1 pair of glasses per year (or contact lenses in lieu of glasses)       No charge       No charge       No charge         Oral Exam       Preventive - Cleaning       Preventive - Cleaning       Preventive - Cleaning       No charge       No charge         Preventive - X-ray       Sealants per Tooth       Preventive - X-ray       No charge       No charge       No charge         Sealants per Tooth       Topical Fluoride Application       Space Maintainers - Fixed       Preventive - Charge       Preventive - Charge       Preventive - Charge       Preventive - Charge         Child Dental Basic       Restorative Procedures       Periodontal Maintenance Services       Pairodontics       <	health needs	Durable medical equipment	40%	x	0%	х
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       No charge         Oral Exam       Preventive - Cleaning       Preventive - Cleaning       Preventive - Cleaning       Preventive - X-ray       Preventive - X-ra		Hospice service	No charge		0%	х
Child Option       1 pair of glasses per year (or contact lenses in lieu of glasses)       No charge       No charge         I pair of glasses per year (or contact lenses in lieu of glasses)       No charge       No charge       No charge         Oral Exam       Preventive - Cleaning       Preventive - Straing       Preventive - Str	Child ovo	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive - Cleaning			-		-	
Preventive - Cleaning       Preventi - Cleaning       Preventive - Cleani			no charge		no charge	
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed       No charge       No c						
Diagnostic and Preventive       Preventive - X-ray       Preventive - X-ray       No charge         Sealants per Tooth       No charge       Preventive - X-ray       Preventive - X-ray         Topical Fluoride Application       Topical Fluoride Application       Preventive - X-ray       Preventive - X-ray         Space Maintainers - Fixed       Space Maintainers - Fixed       Preventive - X-ray       Preventive - X-ray         Child Dental Basic Services       Restorative Procedures       Preventive - X-ray       Preventive - X-ray <th< td=""><td>Child Dental</td><td>Preventive - Cleaning</td><td></td><td></td><td></td><td></td></th<>	Child Dental	Preventive - Cleaning				
Sealants per Tooth       Sealants per Tooth         Topical Fluoride Application       Fixed         Space Maintainers - Fixed       Proceedures         Restorative Procedures       20%         Periodontal Maintenance Services       20%         Crowns and Casts       Findodontics         Periodontics (other than maintenance)       50%         Prosthodontics       50%         Oral Surgery       Oral Surgery	Diagnostic	Preventive - X-ray	No charge		No charge	
Topical Fluoride Application       Topical Fluoride Application       Image: Comparison of the stream of th		Sealants per Tooth	i to ondigo		ino ondigo	
Child Dental Basic Services       Restorative Procedures       20%       20%       20%         Periodontal Maintenance Services       Crowns and Casts       Crowns and Casts       20% <t< td=""><td></td><td>Topical Fluoride Application</td><td></td><td></td><td></td><td></td></t<>		Topical Fluoride Application				
Child Dental Basic Services       Restorative Procedures       20%       20%       20%         Periodontal Maintenance Services       Crowns and Casts       Crowns and Casts       20% <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
Basic Services     20%     20%       Periodontal Maintenance Services     20%     20%       Crowns and Casts     Endodontics     Findodontics       Periodontics (other than maintenance)     50%     50%       Prosthodontics     Forsthodontics     50%       Oral Surgery     Oral Surgery     Forsthodontics	Child Dental					
Child Dental Major Services       Crowns and Casts       Endodontics         Periodontics (other than maintenance)       50%       50%         Prosthodontics       Ford Surgery       Ford Surgery			20%		20%	
Child Dental     Endodontics       Major     Services       Services     Periodontics (other than maintenance)       Prosthodontics     50%       Oral Surgery     Image: Comparison of the service of th	Services	Periodontal Maintenance Services				
Child Dental Major Services     Periodontics (other than maintenance)     50%     50%       Prosthodontics     Oral Surgery     0     1		Crowns and Casts				
Major Services     Periodontics (other than maintenance)     50%     50%       Prosthodontics     Oral Surgery     6     6		Endodontics				
Services Prosthodontics Oral Surgery		Periodontics (other than maintenance)	50%		50%	
Oral Surgery		, ,				
	<b>A</b> 1 11 5	Oral Surgery				

Date: June 16, 2022 July 20, 2023

tuarial Value - A		V	integrated
	Plan design includes a deductible?		integrated
	Integrated Individual deductible		<u>9,450</u> integrated
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$10,200</del> <u>\$</u>	18,900 integrated
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
		¢0.1	00 <u>\$9,450</u>
	Individual Out–of–pocket maximum Family Out-of-pocket maximum		<del>00 <u>99,430</u> 00</del> \$18,900
	HSA plan: Self-only coverage deductible	<del>910,2</del>	N/A
	HSA family plan: Individual deductible		N/A
Common Medical	Service Type	Member Cost Share	Deductible Applie
Event	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no
Health care			preventive visits
provider's office or	Other practitioner office visit	0%	preventive visits
clinic visit	Specialist visit	0%	x
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	х
Tests	X-rays and Diagnostic Imaging	0%	x
			x
	Imaging (CT/PET scans, MRIs)	0%	
	Tier 1	0%	х
	Tier 2	0%	x
Drugs to treat illness		270	
or condition	Tier 3	0%	х
	Tier 4	0%	x
_	Surgery facility for (o.g. ASC)	00/	v
Outpatient	Surgery facility fee (e.g., ASC)	0%	Х
services	Physician/surgeon fees	0%	Х
	Outpatient visit	0%	x
	Emergency room facility fee (waived if admitted)	0%	Х
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	0%	x
immediate attention			
	Urgent care	0%	After 1st three no preventive visits
Hospital stay	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%	x
Mental	Mental/behavioral health and substance use disorder outpatient office		After 1st three no
health,	visits	0%	preventive visits
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
	Outpatient Rehabilitation and Habilitation services	0%	x
Help recovering or			
other special	Skilled nursing care	0%	Х
health needs	Durable medical equipment	0%	х
	Hospice service	0%	х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	x
	Oral Exam		
	Preventive - Cleaning		
Child Dental			
Diagnostic and	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	00/	v
Basic Services	Periodontal Maintenance Services	0%	Х
	Crowns and Casts		
	Endodontics		
Child Dental		0%	x
Major Services	Periodontics (other than maintenance)	0%	^
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	0%	х

# 2023 2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: June 16, 2022 July 20, 2023

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil 100%-150%		CA Enh CSR Silver 8 150%-200% FPL	
tuarial Value - A	V/ Calculator	94.7%		88.8%	
luanai value - A			)		
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	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	\$1,150	)	\$3,000	
	Family Out-of-pocket maximum	\$2,300	)	\$6,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Aedical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
lealth care rovider's	Other practitioner office visit	\$5		\$15	
ffice or linic visit		¢o			
Infic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
ests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
	Tier 2	\$10		\$25	
rugs to reat illness					
r condition	Tier 3	\$15		\$45	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
	Surgery (acility (ac) (a - ASC))			2007	
outpatient	Surgery facility fee (e.g., ASC)	10%		20%	
ervices	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed	Medical transportation (including emergency and non-emergency)	\$30		\$75	
mmediate		\$3U		\$75	
ttention	Urgent care	\$5		\$15	
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
lospital stay	delivery, mental health, and substance use)	10%		20%	
	Physician/surgeon fee	10%		20%	
lental ealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ehavioral ealth, or ubstance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
buse needs regnancy	Prenatal care and preconception visits	No charge		No charge	
sgnancy		No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
lelp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
ecovering or ther special	Skilled nursing care	10%		20%	
ealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
hild Dental	Preventive - X-ray				
iagnostic nd		No charge		No charge	
reventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
asic ervices	Periodontal Maintenance Services	20%		20%	
er vices					
	Crowns and Casts				
child Dental	Endodontics				
lajor	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
Services	Prosthodontics Oral Surgery				

Date: June 16, 2022 July 20, 2023

	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	
tuarial Value - A	V Calculator	79.5%	
	Plan design includes a deductible?	No	
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out–of–pocket maximum	\$6,100	
	Family Out-of-pocket maximum	\$12,200	
	HSA plan: Self-only coverage deductible	N/A	
-	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
Haalth aara	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
	Tion 2	A	
Drugs to treat illness	Tier 2	\$55	
or condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
_	Surgery facility fee (e.g., ASC)	30%	
Outpatient			
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$35	
	č		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	2007	
Hospital stay	delivery, mental health, and substance use)	30%	
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35	
behavioral	visits	çõõ	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or			
other special health needs	Skilled nursing care	30%	
in necus	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		No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	20,0	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics	/0	
	Oral Surgery		

Date: June 16, 2022 July 20, 2023

Summary of Benefits and Coverage

Individual-only Platinum

nber Cost Share amounts describe the Enrollee's out of pocket costs.		Individual-only Platinum Coinsurance Plan		Individual-only Platinum Copay Plan	
tuarial Value - A	V Calculator	<del>91.8%</del> <u>91.9</u>	<u>%</u>	<del>89.8%</del> <u>90.7</u>	<u>'%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental				
		\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out–of–pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	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	\$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					
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	<del>\$5</del> \$7		<del>\$5</del> \$7	
Drugs to	Tier 2	<del>\$15</del> \$16		<del>\$15</del> \$16	
reat 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%		<del>\$100</del> \$75	
Dutpatient	Physician/surgeon fees	10%		<del>\$25</del>	
ervices	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed mmediate Ittention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100/		<del>\$250</del> \$225 per day	
Hospital stay	delivery, mental health, and substance use)	10%		up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
ealth, or substance buse 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	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
ecovering or other special	Skilled nursing care	10%		\$150 \$125 per day up to 5 days	
ealth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
child Dental	Preventive - X-ray				
Diagnostic		Not Covered		Not Covered	
reventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
lasic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
<i>N</i> ajor	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

#### 9.5 FHB Date: June 16, 2022 July 20, 2023 CCSB-only CCSB-only Summary of Benefits and Coverage Platinum Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan **Copay Plan** Actuarial Value - AV Calculator <del>90.7%</del> <u>91.2%</u> <del>88.8%</del> <u>89.4%</u> Plan design includes a deductible? No No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Individual Out-of-pocket maximum \$4,500 \$4,500 Family Out-of-pocket maximum \$9,000 \$9,000 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Member Cost Member Cost Deductible Applies Deductible Applies Service Type Medical Sha Sha Event Primary care visit to treat an injury, illness, or condition \$15 \$20 Health care provider's office or Other practitioner office visit \$15 \$20 clinic visit Specialist visit \$30 \$30 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$15 \$20 Tests X-rays and Diagnostic Imaging \$30 \$30 Imaging (CT/PET scans, MRIs) 10% \$100 Tier 1 \$5 \$10 Tier 2 \$25 \$20 Drugs to treat illnes or condition Tier 3 \$40 \$30 10% up to \$250 per 10% up to \$250 per Tier 4 . script script Surgery facility fee (e.g., ASC) \$100 10% 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) $% \label{eq:starses}$ \$250 per day up to 5 days 10% Hospital stay Physician/surgeon fee 10% No charge Mental Mental/behavioral health and substance use disorder outpatient office \$15 \$20 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance \$15 \$20 abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$20 Help recovering or \$150 per day up to Skilled nursing care 10% other special health needs 5 days Durable medical equipment 10% 10% Hospice service No charge No charge No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic Not Covered Not Covered and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Not Covered Basic Periodontal Maintenance Services Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) Major Not Covered Not Covered Services Prosthodontics Oral Surgery

Not Covered

Not Covered

Child

Medically necessary orthodontics

#### 2023 2024 Patient-Centered Benefit Plan Designs

Date: June 16, 2022 July 20, 2023

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - A	/ Calculator	81.9%		<del>80.1%</del> 81.5	<b>i%</b>
	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	h	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	<del>\$8,550</del> <u>\$8,7</u>		<del>\$8,550</del> <u>\$8,7</u>	
	Family Out-of-pocket maximum	<del>\$17,100</del> <u>\$17,4</u>	<u>400</u>	<del>\$17,100</del> <u>\$17</u> .	<u>.400</u>
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
lealth care provider's office or	Other practitioner office visit	\$35		\$35	
linic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No oborgo	
	·			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	
	·	ψισ		ψισ	
rugs to	Tier 2	\$60		\$60	
eat illness	Tior 2	¢05		¢or.	
r condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	<del>20%</del> 30%		<del>\$150</del> <u>\$130</u>	
outpatient	Physician/surgeon fees	<del>20%</del> 30%		\$40	
ervices					
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed	Medical transportation (including emergency and non-emergency)	\$250		\$250	
mmediate					
ttention	United and	Ac -		Ac -	
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$350 \$330 per day	
lospital stay	delivery, mental health, and substance use)	30%		up to 5 days	
	Physician/surgeon fee	30%		No charge	
lental	Mental/behavioral health and substance use disorder outpatient office				
ealth,	visits	\$35		\$35	
ehavioral ealth, or					
ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
lelp	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
ecovering or				\$150 per day up to	
ther special ealth needs	Skilled nursing care	30%		5 days	
cardi needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
		. to onlarge		. to onlarge	
	Oral Exam				
hild Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
nd	Sealants per Tooth	NUL COVEIEU			
reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
bild Dented					
child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
Child Dental		Not Ocurre 1		Not Occurrent	
Aajor Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgary				
	Oral Surgery				

# 2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 July 20, 2023

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Plan		CCSB-only Gold Copay Plan		
ctuarial Value - A	V Calculator	<del>78.9%</del>		<del>80.5%</del> <u>80.7%</u>		
luanar value - A	Plan design includes a deductible?	Yes, Medical/Pharma	201	Yes, Medical/Pharr	nacy	
	Integrated Individual deductible	N/A	acy	N/A	nacy	
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0		
	Individual Out–of–pocket maximum	\$7,800		\$7,800		
	Family Out-of-pocket maximum	\$15,600		\$15,600		
	HSA plan: Self-only coverage deductible	N/A		N/A		
Common	HSA family plan: Individual deductible	N/A Deductible		N/A		
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care provider's	Other practitioner office visit	\$25		\$35		
office or						
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	х	
	Tier 1	\$15		\$15		
	Tier 2	\$50		\$40		
Drugs to treat illness						
or condition	Tier 3	\$80		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300	х	
Outpatient services	Physician/surgeon fees	20%		\$35		
Services	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	х	\$250	х	
	Emergency room physician fee (waived if admitted)	No charge	~	No charge	~	
Need		-		_	~	
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	20%	X	\$600 per day up to 5 days	х	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	x	No charge		
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%	x	\$300 per day up to 5 days	х	
other special health needs	-		^		^	
	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	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					
Child Dental	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics					
	Oral Surgery					

#### 2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 July 20, 2023

Summary of Benefits and Coverage

2250 01010	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver Plan		
uarial Value - A	V Calculator	<del>71.6%</del>		
	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	<del>\$9,500</del>	<u>300</u> / \$0	
	Individual Out–of–pocket maximum	<del>\$8,750</del>		
	Family Out-of-pocket maximum	<del>\$17,500</del> <u>\$18,200</u>	<u>)</u>	
	HSA plan: Self-only coverage deductible	N/A		
	HSA family plan: Individual deductible	N/A		
Common Medical Event	Service Type	Member Cost Share	Deductib Applies	
	Primary care visit to treat an injury, illness, or condition	<del>\$45</del>		
Health care	Other practitioner office visit	¢45 ¢50		
provider's	Other practitioner once visit	\$45 <u>\$50</u>		
clinic visit	Specialist visit	<del>\$85</del>		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$50		
Tests	X-rays and Diagnostic Imaging	\$95		
	Imaging (CT/PET scans, MRIs)	\$325		
			Pharma	
	Tier 1	<del>\$16</del>	deductik	
Drugs to	Tier 2	\$60	Pharma deductik	
reat illness			Pharma	
or condition	Tier 3	\$90	deductib	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductik	
	Surgery facility fee (e.g., ASC)	<del>20%</del> 30%		
Outpatient	Physician/surgeon fees	<del>20%</del> 30%		
services				
	Outpatient visit	<del>20%</del> 30%		
	Emergency room facility fee (waived if admitted)	<del>\$400</del> \$450		
	Emergency room physician fee (waived if admitted)	No charge		
Need	Medical transportation (including emergency and non-emergency)	\$250		
mmediate attention				
	Urgent care	<b>\$45</b> <u>\$50</u>		
		· · · · · · · · · · · · · · · · · · ·		
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and			
Hospital stay	delivery, mental health, and substance use)	30%	X	
	Physician/surgeon fee	30%		
Mental	Mental/behavioral health and substance use disorder outpatient office			
health, behavioral	visits	<del>\$45</del>		
health, or	Mental/behavioral health and substance use disorder other outpatient			
substance abuse needs	items and services	<del>\$45</del>		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$45		
Help recovering or	Outpatient Rehabilitation and Habilitation services	<del>\$45</del>		
recovering or other special	Skilled nursing care	30%	х	
health needs	Durable medical equipment	20%		
	Hospice service	No charge		
	Eye exam	No charge		
Child eye care	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	Restorative Procedures			
Basic	Periodontal Maintenance Services	Not Covered		
Services				
	Crowns and Casts			
Child Dental	Endodontics			
Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
			1	
	Oral Surgery			

### Date: June 16, 2022 July 20, 2023

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plan		Silver Copay Plan		
tuarial Value - A	V Calculator	<del>71.9%</del> <u>70.0%</u>		<del>71.7%</del> <u>69.7%</u>		
luanar value - A	Plan design includes a deductible?		acv	Yes, Medical/Pharm	acv	
	Integrated Individual deductible	N/A	.09	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 Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie	
_vent	Primary care visit to treat an injury, illness, or condition	\$55		\$55		
Health care						
provider's office or	Other practitioner office visit	\$55		\$55		
clinic visit	Specialist visit	\$90		\$90		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$55		\$55		
Tests	X-rays and Diagnostic Imaging	\$90		\$90		
	Imaging (CT/PET scans, MRIs)	35%	х	\$300	х	
			^		X	
	Tier 1	\$20		\$19		
	Tier 2	\$75	Pharmacy	\$85	Pharm	
Drugs to treat illness			deductible Pharmacy		deduct Pharm	
or condition	Tier 3	\$105	Pharmacy deductible	\$110	deduct	
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharm deduct	
	Surgery facility fee (e.g., ASC)	35%	Х	35%	Х	
Outpatient	Physician/surgeon fees	35%		<del>30%</del> 35%		
services	Outpatient visit	35%		<del>30%</del> 35%		
			V	<del>30%</del> 35%	V	
	Emergency room facility fee (waived if admitted)	35%	Х		Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate attention	Medical transportation (including emergency and non-emergency)	35%	Х	<del>30%</del> 35%	Х	
	Urgent care	\$55		\$55		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	35%	х	<del>40%</del> 35%	х	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	35%	x	4 <del>0%</del> 35%	X	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55		
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$55		\$55		
abuse needs		No oborgo		No shores		
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 other special	Skilled nursing care	35%	х	<del>40%</del> 35%	Х	
health needs	Durable medical equipment	35%		<del>40%</del> 35%		
	Hospice service	No charge		No charge		
Child out	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	_		_		
		No charge		No charge		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
and Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					

# 2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 July 20, 2023

Oral Surgery

Medically necessary orthodontics

Not Covered

Child Orthodo

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	, -
ctuarial Value - A	V Calculator	71.7%	
	Plan design includes a deductible?	Yes, integ	
	Integrated Individual deductible	\$ <del>2,700</del> <u>\$2,850</u>	
	Integrated Family deductible	<del>\$5,400</del> <u>\$5,700</u>	-
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out–of–pocket maximum	<del>\$7,200</del>	<u>,500</u>
	Family Out-of-pocket maximum	<del>\$14,400</del>	<u>5,000</u>
	HSA plan: Self-only coverage deductible	<del>\$2,700</del>	. <u>.850</u>
<b>C</b> emmon (	HSA family plan: Individual deductible	See endr	note
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	25%	x
Health care provider's	Other practitioner office visit	25%	x
office or clinic visit	Specialist visit	25%	x
	Preventive care/ screening/ immunization		
	•	No charge 25%	x
Tests	Laboratory Tests		x
10313	X-rays and Diagnostic Imaging	25%	
	Imaging (CT/PET scans, MRIs)	25%	X
	Tier 1	25% up to \$250 per script	х
	Tier 2	25% up to \$250 per	x
Drugs to treat illness		script 25% up to \$250 per	
or condition	Tier 3	script	X
	Tier 4	25% up to \$250 per script	x
	Surgery facility fee (e.g., ASC)	25%	х
Outpatient services	Physician/surgeon fees	25%	x
	Outpatient visit	25%	x
	Emergency room facility fee (waived if admitted)	25%	x
	Emergency room physician fee (waived if admitted)	0%	x
Need	Medical transportation (including emergency and non-emergency)		x
immediate		25%	^
attention			
	Urgent care	25%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	x
Hospital stay	Physician/surgeon fee	25%	x
Mental			
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	25%	X
health, or 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	
	Home health care (cost share per visit)	25%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	25%	X
other special	Skilled nursing care	25%	x
health needs	Durable medical equipment	25%	x
	Hospice service	0%	х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
Child Dent-	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

Date: June 16, 2022 July 20, 2023

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL	
tuarial Value - A	V Calculator	94.9%	, 0	87.9%	
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pharm	nacy
	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 / <mark>\$25 <u>\$50</u> /</mark> \$	\$O
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$1,600 / <del>\$50</del> <u>\$100</u> /	\$0
	Individual Out-of-pocket maximum	<del>\$900</del> <u>\$1,</u>	<u>150</u>	<del>\$3,000</del>	
	Family Out-of-pocket maximum	<del>\$1,800</del>	<u>2.300</u>	\$ <del>6,000</del>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
provider's	Other practitioner office visit	\$5		\$15	
linic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
ests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)				
	inaging (CT/TET Sodis, IVINS)	\$50		\$100	Dharm
	Tier 1	\$3		<del>\$5</del> \$6	Pharma deductil
	Tier 2	\$10		\$25	Pharma
Drugs to reat illness		ΨIU		ΨZŪ	deductil
or condition	Tier 3	\$15		\$45	Pharma deductit
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharma deductil
	Surgery facility fee (e.g., ASC)	10%		<del>15%</del> 20%	
Dutpatient	Physician/surgeon fees	10%		<del>15%</del> 20%	
ervices				<del>15%</del> 20%	
	Outpatient visit	10%			
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	х	<del>25%</del> 20%	x
lospital stay	delivery, mental health, and substance use)			<del>25%</del> 20%	
• · · · · · ·	Physician/surgeon fee	10%		<del>23%</del> 20%	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
nealth, 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	
lolp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
lelp ecovering or			v		
other special lealth needs	Skilled nursing care	10%	Х	<del>25%</del> 20%	X
icann needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
child Dental	Preventive - X-ray				
Diagnostic Ind		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				
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
					1
	Oral Surgery				

### 2023 2024 Patient-Centered Benefit Plan Designs 9.5 EHB Date: June 16, 2022 July 20, 2023

Summary of Benefits and Coverage

mber Cost Shafe	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	-
uarial Value - A	V Calculator	<del>73.9%</del> 74.0%	
	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> / \$30 <u>\$1</u>	<u>50</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$9,500</del>	<u>300</u> / \$0
	Individual Out–of–pocket maximum	<del>\$7,250</del>	
	Family Out-of-pocket maximum	<del>\$14,500</del> <u>\$15,100</u>	<u>)</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common			Deductibl
Medical Event	Service Type	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$45 <u>\$50</u>	
provider's office or	Other practitioner office visit	\$4 <del>5</del>	
clinic visit	Specialist visit	<del>\$85</del>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	<del>\$90</del>	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	<del>\$16</del>	Pharmac
		410 <u>410</u>	deductib Pharma
Drugs to	Tier 2	\$55	Pharma deductib
reat illness or condition	Tier 3	\$85	Pharma deductib
	Tier 4	20% up to \$250 per script	Pharmad
_		after pharmacy deductible	deductio
Outpatient	Surgery facility fee (e.g., ASC)	<del>20%</del> 30%	
services	Physician/surgeon fees	<del>20%</del> 30%	
	Outpatient visit	<del>20%</del> 30%	
	Emergency room facility fee (waived if admitted)	<del>\$400</del> \$450	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention	Urgent care	<del>\$45</del> \$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	201/	Y
Hospital stay	delivery, mental health, and substance use)	30%	Х
	Physician/surgeon fee	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$45 <u>\$50</u>	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>\$45</del>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
lolp	Outpatient Rehabilitation and Habilitation services	\$45 <u>\$50</u>	
Help recovering or	Skilled nursing care	30%	x
other special nealth 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	Restorative Procedures	Net Or	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
	oral outgoty		

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

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plar	n
uarial Value - A	/ Calculator	CA 70/ CA 10/		64.00/.04.0/	0/
uariai value - A		64.7% 64.4%	2004	64.2%_64.9	
	Plan design includes a deductible?	Yes, Medical/Pharr N/A	nacy	Yes, integrated \$7,000 \$7,050 integrate	
	Integrated Individual deductible				-
	Integrated Family deductible	N/A		<del>\$14,000</del> <u>\$14,100</u> ir N/A	itegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$		N/A	
		\$12,600 / \$1,000 / <del>\$8,200</del> \$9,100		\$ <del>7,000</del> \$7,0	50
	Individual Out-of-pocket maximum	<del>\$6,200</del> \$3,100 <del>\$16,400</del> \$18,20		<del>\$14,000</del> \$14,0	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	N/A	0	\$ <del>7,000</del> \$7,0	
	HSA family plan: Individual deductible	N/A		<del>\$7,000</del> \$7,0	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
Event	Primary care visit to treat an injury, illness, or condition	\$ <del>65</del> <u>\$60</u>	After 1st three non- preventive visits	0%	x
Health care provider's	Other practitioner office visit	<del>\$65</del>	After 1st three non-	0%	х
office or		<del>403</del> <u>400</u>	preventive visits	078	^
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	х
ests	X-rays and Diagnostic Imaging	40%	x	0%	х
	Imaging (CT/PET scans, MRIs)	40%	x	0%	x
	Tier 1	<del>\$18</del> \$17	Pharmacy Deductible	0%	Х
Drugs to	Tier 2	40% up to \$500 per script after	Pharmacy	0%	х
reat illness		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy		
or condition	Tier 3	pharmacy deductible	Deductible	0%	х
	Tier 4	40% up to \$500 per script after	Pharmacy	0%	x
		pharmacy deductible	Deductible	070	~
	Surgery facility fee (e.g., ASC)	40%	Х	0%	Х
Outpatient ervices	Physician/surgeon fees	40%	х	0%	х
	Outpatient visit	40%	x	0%	х
	Emergency room facility fee (waived if admitted)	40%	х	0%	х
	Emergency room physician fee (waived if admitted)	No charge		0%	x
laad			, v		
Need mmediate attention	Medical transportation (including emergency and non-emergency)	40%	X	0%	Х
	Urgent care	<del>\$65</del>	After 1st three non- preventive visits	0%	х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	x	0%	х
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	40%	X	0%	Х
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	<del>\$65</del>	After 1st three non- preventive visits	0%	х
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>\$65</del>	×	0%	х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	х
					x
lelp ecovering or	Outpatient Rehabilitation and Habilitation services	<del>\$65</del>		0%	
other special	Skilled nursing care	40%	Х	0%	х
ealth needs	Durable medical equipment	40%	х	0%	х
	Hospice service	No charge		0%	х
child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam			. to only go	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
nd Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered	
CI VICES					
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
bei vices	Prosthodontics				
	Oral Surgery				

Date: June 16, 2022 July 20, 2023

tuarial Value - A			
	Plan design includes a deductible?		integrated
	Integrated Individual deductible		0,450 integrated
	Integrated Family deductible	<del>\$18,200</del> <u>5</u> 1	18,900 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	¢0.4	N/A
	Individual Out–of–pocket maximum		<del>00</del>
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	<del>\$10,2</del>	900 <u>\$18,900</u> N/A
	HSA family plan: Individual deductible		N/A
Common Medical	Service Type	Member Cost Share	Deductible Applie
Event	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three no
office or			preventive visits
clinic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	x
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	х
Drugs to	Tier 2	0%	x
treat illness or condition	Tier 3	0%	x
or condition			
	Tier 4	0%	х
Outpatient	Surgery facility fee (e.g., ASC)	0%	Х
services	Physician/surgeon fees	0%	х
	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		0,0	
attention	Urgent care	0%	After 1st three no preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	x
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visits
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	0%	x
abuse needs Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Help recovering or	Outpatient Rehabilitation and Habilitation services	0%	X
other special	Skilled nursing care	0%	Х
health needs	Durable medical equipment	0%	х
	Hospice service	0%	x
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	x
	Oral Exam	070	~
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
00111003			
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

Date: June 16, 2022 July 20, 2023

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil 100%-1509		CA Enh CSR Silver 87 150%-200% FPL	
tuarial Value - A		94.7%	2	88.8%	
	Plan design includes a deductible?	No N/A		No	
	Integrated Individual deductible Integrated Family deductible	N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$1,150		\$3,000	
	Family Out-of-pocket maximum			\$6,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
lealth care rovider's	Other practitioner office visit	\$5		\$15	
ffice or linic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
ests	X-rays and Diagnostic Imaging	фо \$8		\$40	
0313					
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
	Tier 2	\$10		\$25	
Prugs to reat illness		φιυ		φζυ	
r condition	Tier 3	\$15		\$45	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient	Physician/surgeon fees	10%		20%	
ervices					
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed nmediate ttention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		20%	
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
lental ealth, ehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ealth, or ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
lelp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
ecovering or ther special	Skilled nursing care	10%		20%	
ealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
hild eye are	Eye exam	No charge		No charge	
uro	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
hild Dental	Preventive - X-ray	Net Orace 1		Net Original 1	
nd	Sealants per Tooth	Not Covered		Not Covered	
reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
asic		Not Covered		Not Covered	
ervices	Periodontal Maintenance Services				
	Crowns and Casts				
child Dental	Endodontics				
lajor	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Trodulodoniloo				
	Oral Surgery				

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

	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	
tuarial Value - A	V Calculator	79.5%	
	Plan design includes a deductible?	No	
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out–of–pocket maximum	\$6,100	
	Family Out-of-pocket maximum	\$12,200	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common			Deductibl
Medical Event	Service Type	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$35	
provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$85	
	· Preventive care/ screening/ immunization	No charge	
	-	\$50	
	Laboratory Tests		
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
Drugs to	Tier 2	\$55	
treat illness or condition	<b>T</b> = 0	005	
	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
Services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
N	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	
Hospital stay	delivery, mental health, and substance use)		
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
recovering or	Skilled nursing care	30%	
other special health needs	-		
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Coursed	
and Preventive	Sealants per Tooth	Not Covered	
reventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
Gervices			
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
00111003	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

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

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

#### Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2023 2024 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans 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.
- Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).

- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California <u>2023</u> <u>2024</u> Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, <u>Podiatrists,</u> acupuncture practitioners, Registered

Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

- 19) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
- 20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
- 21) Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).
- 22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
- 23) Drug tiers are defined as follows:

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