Covered California 2024 2025 Patient-Centered Benefit Plan Designs¹

Proposed

February 15, 2024

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

Date: July 20, 2023 February 15, 2024

Summary of Benefits and Coverage



Summary of Ber	nefits and Coverage	тм			
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only I Coinsurance			
		Comsulance	FIGII	Сорау г іа	
Actuarial Value - A\	√ Calculator	91.9%		90.7% <u>91.6</u>	<u>1</u> %
	Plan design includes a deductible?	No			
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0			
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$:0		0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$			
	Individual Out-of-pocket maximum	\$4,500			
	Family Out-of-pocket maximum				
	HSA plan: Self-only coverage deductible				
Common	HSA family plan: Individual deductible	IN/A		IN/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
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			
Tanta	·				
Tests	X-rays and Diagnostic Imaging	\$30		No \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$7		\$7	
Drugs to treat	Tier 2	\$16		\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	
illness or					
condition	Tier 3	\$25			
	Tier 4	10% up to \$250 per script			
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient	Physician/surgeon fees	10%			
services					
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate attention					
	Urgent care	\$15		\$15	
	Organic surio	Ψίδ		Ψίδ	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$205 per devine to	
Hospital stay	delivery, mental health, and substance use)	10%			
,	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$15		\$15	
health, or	Na				
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$15			
other special	Skilled nursing care	10%		\$0 / \$0 / \$0 \$0 \$0 / \$0 \$0 \$0	
health needs	Durable medical equipment	10%			
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		_	
	Oral Exam	. 13 Gridinge			
				\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge			
and Preventive	Sealants per Tooth	l sa salargo			
riovonavo	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2024 2025	
Basic		20%		Dental Copay	
Services	Periodontal Maintenance Services			Scnedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2024 2025	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB Date: July 20, 2023 February 15, 2024

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	Platinum	Ī	Platinum	ĺ
tuarial Value - A\	/ Calculator	01.2% 01.3	0/2	<u>80.4%</u> 00.5	i%
uariai value - At	Plan design includes a deductible?		<u> </u>		<u> </u>
	Integrated Individual deductible				
	Integrated Family deductible				
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	·	0		0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental				
	Individual Out-of-pocket maximum				
	Family Out-of-pocket maximum				
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Dedu App
Volit	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
lealth care	Other practitioner office visit	¢4E		¢20	
	Other practitioner office visit	\$15		\$20	
linic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
ests	X-rays and Diagnostic Imaging				
	Imaging (CT/PET scans, MRIs)				
			N/A N/A Alember Cost Share Deductible Applies Member Cost Share Deal Applies \$15 \$20 \$15 \$20 \$30 \$30 No charge No charge \$15 \$20 \$30 \$30 10% \$100 \$10 \$5 \$25 \$20 \$40 \$30		
	Tier 1	\$10		\$5	
Truce to troot	Tier 2	\$25		\$20	
orugs to treat				·	
condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script			
	Surgery facility fee (e.g., ASC)	10%		\$100	
_	Physician/surgeon fees	10%		\$25	
sei vices	Outpatient visit	10%		\$25 10% \$150 No charge	
	Emergency room facility fee (waived if admitted)				
Need immediate attention					
	Emergency room physician fee (waived if admitted)			_	
	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$20	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee			5 days	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	_		_	
	Outpatient Rehabilitation and Habilitation services	-			
Help recovering or		·			
other special	Skilled nursing care	10%			
nealth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eve	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	_		_	
	Oral Exam	<u> </u>		<u> </u>	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
dealth care provider's effice or elinic visit. Tests Drugs to treat liness or condition. Dutpatient dervices. Description of the dealth, or condition. Doubstance base needs. Dregnancy. Defined eleath, or condition. Description of the dealth, or condition. Description of the dealth of th	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2024 Dental	
Basic Bervices	Periodontal Maintenance Services	20%			
	Crowns and Casts				
	Endodontics				
Child Dental				See 2024 Dental	
Major Services	Periodontics (other than maintenance)	50%			
	Prosthodontics				
	Oral Surgery				

2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB Date: July 20, 2023 February 15, 2024

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% 81.5°	0/2	81 5% 81 6	:0/,
ualiai value - A			<u>70</u>		<u>170</u>
	-	\$0			
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$8,700		\$8,700	
	Family Out-of-pocket maximum			\$17,400	
				N/A	
Cammon	HSA family plan: Individual deductible	N/A		N/A	
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie
-vonc	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
	Other practitioner office visit	\$35		\$35	
office or	·	·			
clinic visit	•				
	•	_		-	
	·				
ests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
	Tier 2	\$60		\$60	
Prugs to treat Iness or ondition Dutpatient ervices	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per		20% up to \$250 per	
	Surgery facility fee (e.g. ASC)	·		·	
_				\$0 / \$0 / \$0 \$0 / \$0 / \$0 \$8,700 \$17,400 N/A N/A Member Cost Share \$35 \$65 No charge \$40 \$75 \$75 \$15 \$60 \$85	
services					
Need mmediate attention Hospital stay Mental health, hehavioral health, or					
	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0001		\$330 \$350 per dav	
Hospital stay	delivery, mental health, and substance use)	30%		' '	
	Physician/surgeon fee	30%		No charge	
	Mental/behavioral health and substance use disorder outpatient office	\$35		\$35	
pehavioral	VISILS			\$17,400 N/A	
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		_	
lalm					
Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Survival Advanced in Pharmacy / Dental Major / Dental Ma					
				5 days	
Sulli needs	Integrated Individual deductable individual deductable individual deductable individual deductable, NOT integrated: Medical / Pharmary / Dental Family deductable, NOT integrated: Medical / Pharmary / Dental So / 80 / 80 83,700 83,800				
		-		-	
		_		_	
out 6		No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Restorative Procedures	20%			
	Periodontal Maintenance Services	2070			
	Crowns and Casts				
Child Dental	Endodontics			See 2024 2025	
Major	Periodontics (other than maintenance)	50%		Dental Copay	
bervices	Prosthodontics			Schedule	
Adedical Event Health care provider's effice or elinic visit Fests Drugs to treat liness or condition Dutpatient elevices Health, or condition Hospital stay Annual lealth, or cubstance elibuse needs Pregnancy Help ecovering or other special lealth needs Child bental biagnostic and preventive Child Dental biagnostic and preventive	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

· · · · · · · · · · · · · · · · · · ·	nefits and Coverage	CCSB-only		CCSB-only	
-	amounts describe the Enrollee's out of pocket costs.	Gold		Gold	
500. Onuit		Coinsurance Pla	n	Copay Plan	
Actuarial Value - A\	/ Calculator	78.8% <u>79.1%</u>		80.7% 80.5%	
/ totaliai valab / t	Plan design includes a deductible?		acv		macv
	Integrated Individual deductible	N/A	аоу		nacy
	Integrated Family deductible	N/A			
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0			
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0			
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$25	**	\$35	
Health care					
provider's office or	Other practitioner office visit	\$25		80.7% 80.5% Yes, Medical/Pharm N/A N/A \$250 / \$0 / \$0 \$500 / \$0 / \$0 \$7,800 \$15,600 N/A N/A	
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			
	Imaging (CT/PET scans, MRIs)	20%			X
					^
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$40	
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	Physician/surgeon fees	20%		\$35	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	×		X
			^	·	Α
Need	Emergency room physician fee (waived if admitted)	No charge			
Need immediate attention	Medical transportation (including emergency and non-emergency)	20%	X	Yes, Medical/Pharm	X
	Urgent care	\$25		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20% 20%	X X		Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25	^	-	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$25		¢25	
abuse needs	items and services				
Pregnancy	Prenatal care and preconception visits	No charge			
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
recovering or other special	Skilled nursing care	20%	x	\$300 per day up to 5 days	Х
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child	Eye exam	No charge		_	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		_	
	Oral Exam	140 Glaige		140 Glaige	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	000/		See 2024 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%			
	Crowns and Casts				
Child Daniel	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%			
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics	incurcanty ricocosary orthodolitics	JU76		φ1,000	

Summary	of	Benefits	and	Coverage
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•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
Member Cook Chare	uniodito describe tre Emolece editor positet ecolo.	marvidual-only onver	T IGH
Actuarial Value - A	V Calculator	71.8% <u>71.6%</u>	
	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	\$5,400 / <mark>\$150</mark> <u>\$50</u> /	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$300 <u>\$100</u>	/ \$0
	Individual Out-of-pocket maximum	\$ 9,100 <u>\$8,700</u>	
	Family Out-of-pocket maximum	\$18,200 <u>\$17,400</u> N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A	
Common	,,		Dadostibla
Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care provider's	Other practitioner office visit	\$50	
office or clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	D
Drugs to treat	Tier 2	\$60	Pharmacy deductible
illness or condition	Tier 3	\$90	Pharmacy
			deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
Services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$450 \$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate	measure and personal (modaling emergency and non-emergency)	Ψ200	
attention	Herapit care	\$ 50	
	Urgent care	\$50	
	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 health,	Mental/behavioral health and substance use disorder outpatient office	\$50	
behavioral	visits	, , ,	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$50	
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help .	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other special	Skilled nursing care	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 Services	Periodontal Maintenance Services	20%	
00111003	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics	JU /0	
	Oral Surgery		
Child	• ,		
Orthodontics	Medically necessary orthodontics	50%	

	nefits and Coverage	CCSR-only		CCSR-only	
-	refits and Coverage	CCSB-only Silver		CCSB-only Silver	
wernber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan	1	Copay Plan	
Actus	/ Calculator	700/ 00 50/		00.701.00.401	
Actuarial Value - A\		70% <u>69.5%</u>			
	Plan design includes a deductible?	Yes, Medical/Pharma	acy		acy
	Integrated Individual deductible	N/A			
	Integrated Family deductible	N/A			_
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0			
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		1		0
	Individual Out-of-pocket maximum				
	Family Out-of-pocket maximum			\$17,500	
_	HSA family plan: Individual deductible	N/A		N/A	
Common Medical	Service Type	Member Cost Share	Deductible	Member Cost Share	Deductible
Event			Applies		Applies
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care provider's	Other practitioner office visit	\$55		Copay Plan 69.7% 69.1% Yes, Medical/Pharm N/A N/A \$2,500 / \$300 / \$600 / \$	
office or		Service Serv			
clinic visit	Specialist visit	\$90		\$5,000 / \$600 / \$0 \$8,750 \$17,500 N/A N/A N/A Member Cost Share \$55 \$55 \$90 No charge \$55 \$90 \$300 \$19 \$85 \$110 30% up to \$250 per script after pharmacy deductible 35% 35% 35% 35% 35% \$55 No charge 35% \$55 No charge \$45 \$55 \$55 No charge \$45 \$55 \$55 No charge \$45 \$55 \$55 No charge \$45 \$55 \$55 No charge \$45 \$55 \$55 No charge No charge No charge No charge	
	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%	X	\$300	X
			. ,		. ,
	Tier 1	\$20		\$19	
Drugs to treat	Tier 2	\$75		\$85	Pharmacy
illness or					deductible Pharmacy
condition	Tier 3	\$105		\$110	deductible
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharmacy
	1161 4	pharmacy deductible	deductible	pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	35%	X	35%	X
Outpatient services	Physician/surgeon fees	35%		35%	
Services	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)		Y		Y
			^		^
	Emergency room physician fee (waived if admitted)	No charge			
Need immediate	Medical transportation (including emergency and non-emergency)	35%	Х	Yes, Medical/Pharma	Х
attention					
	Urgent care	\$55		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	250/	V	250/	V
Hospital stay	delivery, mental health, and substance use)	35%	^	35%	^
	Physician/surgeon fee	35%	Χ	35%	
Mental	Mental/behavioral health and substance use disorder outpatient office	¢55		¢55	
health, behavioral	visits	φοο		φοο	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$55		\$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	_		_	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
other special	Skilled nursing care	35%	X	35%	X
health needs	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
OF.11	Eye exam	_		_	
Child eye care		_			
		ino charge		ino charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No observe		No oberge	
and	Sealants per Tooth	ino charge		ino charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental					
Basic	Restorative Procedures	20%			
Services	Periodontal Maintenance Services			Gorieutie	
	Crowns and Casts				
Child Daniel	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%			
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	• •			N/A \$2,500 / \$300 / \$ \$5,000 / \$600 / \$ \$8,750 \$17,500 N/A N/A N/A Member Cost Share \$55 \$55 \$90 No charge \$55 \$90 \$300 \$19 \$885 \$110 30% up to \$250 per script after pharmacy deductible 35% 35% 35% 35% 35% 35% \$55 No charge 35% \$55 No charge \$45 \$55 \$55 No charge \$45 \$55 No charge \$45 \$55 No charge \$45 \$55 No charge \$45 \$55 No charge	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Summary of Ben	2023 February 15, 2024 lefits and Coverage	CCSB-o	nly
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver HDHP P	
Actuarial Value - A\	/ Calculator	71.7% <u>71</u>	<u>.2%</u>
	Plan design includes a deductible?	Yes, integ	rated
	Integrated Individual deductible	\$2,850 integ	grated
	Integrated Family deductible	\$5,700 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out–of–pocket maximum	\$7,500)
	Family Out-of-pocket maximum		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
LVOIR	Primary care visit to treat an injury, illness, or condition	25%	х
Health care provider's	Other practitioner office visit	25%	X
office or			
clinic visit	Specialist visit	25%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	X
	Tier 1	25% up to \$250 per	x
		script 25% up to \$250 per	
Drugs to treat	Tier 2	script	X
illness or condition	Tier 3	25% up to \$250 per	X
		script 25% up to \$250 per	
	Tier 4	script	X
	Surgery facility fee (e.g., ASC)	25%	Х
Outpatient	Physician/surgeon fees	25%	X
services	Outpatient visit	25% 25%	X
	Emergency room facility fee (waived if admitted)		X
Need immediate attention	Emergency room physician fee (waived if admitted)	0%	X
	Medical transportation (including emergency and non-emergency)	25%	X
	inedical transportation (including emergency and non-emergency)	25%	^
attention			
	Urgent care	25%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	25%	X
Hospital stay	delivery, mental health, and substance use)		
Marrial	Physician/surgeon fee	25%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	25%	X
behavioral health, or	Volle		
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	Outpatient Rehabilitation and Habilitation services	25%	x
recovering or	Skilled nursing care	25%	X
other special health needs	·		
	Durable medical equipment	25%	X
	Hospice service	0%	X
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	, to sharge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	2021	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics Prosthodontics	5570	
Child	Oral Surgery		
tarrett	Medically necessary orthodontics	50%	

	efits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPL	
ctuarial Value - AV	' Calculator	94 9% 9	1.7%	87 9% 88 0%	
ictuariai value - Av					13CV
	·	,	Паппасу		lacy
			0 / \$0		50 / \$0
					
				\$3,150 \$3,050	
				· -	
			.,000		
				N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	Plan design includes a deducable in Plan design includes a deducable in linguisted any described in history and any described in No.			
	Laboratory Tests	_		_	
Tests	·				
resis					
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$6 \$8	
Drugo to to	Tier 2	\$10		\$25	Pharmacy
Drugs to treat illness or		Ψ10		Ψ20	deductible
condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4			15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient	Physician/surgeon fees				
services					
	Outpatient visit			-	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$30		\$75	
attention					
	Urgent care	\$5		\$15	
Hospital stay	delivery, mental health, and substance use)	10%	Х	20%	Х
1103pital stay	Physician/surgeon fee	10%		20%	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$5		\$15	
health, or	Mental/hehavioral health and substance use disorder other outnations				
substance abuse needs	items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or			v		v
other special health needs	Skilled nursing care		^		X
AGUATAT TICEUS	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services	_5,0		23,0	
	Crowns and Casts				
A	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
Child	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

•	efits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan	
iliber Cost Share a	aniounts describe the Enrollee's out of pocket costs.	200%-250% FPL	-
tuarial Value - A\	/ Calculator	74.0% <u>73.9%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	пасу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / \$150 <u>\$350</u>	/ \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$300 <u>\$700</u>	/ \$0
	Individual Out-of-pocket maximum	\$7,550 <u>\$7,350</u>	.
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$15,100 <u>\$14,700</u> N/A	<u>)</u>
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50 <u>\$35</u>	
Health care provider's	Other practitioner office visit	\$ 50 <u>\$35</u>	
office or clinic visit	Specialist visit	\$90 \$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		
		\$19	Dhar
Drugs to treat	Tier 2	\$55	Pharma deductib
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)	30%	
Outpatient services Physician/surgeon fees Outpatient visit Emergency room facility fee (waived if admitted)	Physician/surgeon fees	30%	
	Outpatient visit	30%	
		\$450 \$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$ 50 <u>\$35</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	^
Mental	Mental/behavioral health and substance use disorder outpatient office	30 70	
health, behavioral health, or	visits	\$50 <u>\$35</u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50 <u>\$35</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$50 <u>\$35</u>	
recovering or other special	Skilled nursing care	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	NI1	
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	222	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	· ,		

Medically necessary orthodontics

Date: July 20, 2023 February 15, 2024

Summary of Benefits and Coverage

ember Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plar	n
ctuarial Value - A\	/ Calculator	64.4% <u>63.7%</u>		64.9%	
	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integrat	ed
	Integrated Individual deductible	N/A	•	\$ 7,050 <u>\$6,650</u> into	egrated
	Integrated Family deductible	N/A		\$14,100 <u>\$13,300</u> ir	ntegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 <u>\$5,800</u> / \$500 <u>\$</u>	<u>450</u> / \$0	N/A	-
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 \$11,600 / \$1,000	\$ <u>900</u> / \$0	N/A	
	Individual Out-of-pocket maximum	\$9,100 \$8,850		\$7,050 \$6,69	50
	Family Out-of-pocket maximum	\$18,200 \$17,70	0	\$14,100 \$13,	300
	HSA plan: Self-only coverage deductible	N/A		\$7,050 \$6,65	50
	HSA family plan: Individual deductible	N/A		\$7,050 \$6,69	50
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$60	After 1st three non- preventive visits	0%	х
Health care provider's	Other practitioner office visit	\$60	After 1st three non-	0%	X
office or		***	preventive visits After 1st three non-		
clinic visit	Specialist visit	\$95	preventive visits	0%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	Х
Tests	X-rays and Diagnostic Imaging	40%	x	0%	×
	Imaging (CT/PET scans, MRIs)	40%	×	0%	X
	Tier 1	\$17 \$19	Pharmacy Deductible	0%	Х
Druge to treet	Tier 2	40% up to \$500 per script after	Pharmacy	0%	×
Drugs to treat illness or		pharmacy deductible	Deductible		
condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
		40% up to \$500 per script after	Pharmacy		
	Tier 4	pharmacy deductible	Deductible	0%	Х
	Surgery facility fee (e.g., ASC)	40%	X	0%	Х
Outpatient	Physician/surgeon fees	40%	x	0%	x
services				## HDHP Plan 64.9% Yes, integrate \$7,050 \$6,650 \$14,100 \$13.300 N/A	
	Outpatient visit	40%	X		Х
	Emergency room facility fee (waived if admitted)	40%	X	0%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need	Medical transportation (including emergency and non-emergency)	40%	X	0%	Х
immediate attention					
	Urgent care	\$60	After 1st three non- preventive visits	0%	Х
	Facility fee (e.g. hospital room) for innations atout (inalishing labor and				
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	Х
Julian July	Physician/surgeon fee	40%	x	0%	x
Mental					
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	Х
behavioral health, or					
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	Х
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
James		40%	X		Х
	Home health care (cost share per visit)		^		
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	Х
recovering or other special	Skilled nursing care	40%	x	0%	Х
health needs	Durable medical equipment	40%	x	0%	x
	Hospice service	No charge			X
	•	-			^
Child eye care	Eye exam	No charge		-	
our o	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray			,	
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services	20 /0		2070	
	Crowns and Casts				
	Endodontics				
Child Dental		500/		E00/	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				

10.0 EHB

Date: July 20, 2023 February 15, 2024

Summary of Benefits and Coverage

	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan	
octuarial Value - A	V Calculator			
	Plan design includes a deductible?		integrated	
	Integrated Individual deductible		1,200 integrated	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$18,900 \$18,400 integrated N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental			
	Individual Out-of-pocket maximum	\$ 9, 4	50 <u>\$9,200</u>	
	Family Out-of-pocket maximum	\$18,9	00 <u>\$18,400</u>	
	HSA plan: Self-only coverage deductible		N/A	
	HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits	
provider's	Other practitioner office visit	0%	After 1st three non- preventive visits	
office or clinic visit	Specialist visit	0%	x	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	0%	x	
Tests	X-rays and Diagnostic Imaging	0%	Х	
	Imaging (CT/PET scans, MRIs)	0%	Х	
	Tier 1	0%	Х	
	Tion 2	001	,	
Drugs to treat illness or condition	Tier 2	0%	X	
	Tier 3	0%	Х	
	Tier 4	0%	х	
	Surgery facility fee (e.g., ASC)	0%	Х	
Outpatient	Physician/surgeon fees	0%	X	
services	Outpatient visit	0%	x	
	Emergency room facility fee (waived if admitted)	0%	x	
	Emergency room physician fee (waived if admitted)	No charge		
Need	Medical transportation (including emergency and non-emergency)	0%	x	
immediate attention				
	Urgent care	0%	After 1st three non- preventive visits	
			proventino tiene	
	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	201	After 1st three non-	
health, behavioral	visits	0%	preventive visits	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	X	
abuse needs	items and services		^	
Pregnancy	Prenatal care and preconception visits	No charge	X	
	Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services	0%	X	
Help recovering or	Outpatient Rehabilitation and Habilitation services	-		
other special health needs	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
	Hospice service	0%	Х	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	x	
	Oral Exam	U 70	^	
	Preventive - Cleaning			
Child Dental	Preventive - X-ray			
Diagnostic and	Sealants per Tooth	No charge		
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Services	0%	Х	
23.11033	Crowns and Casts			
	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	0%	Х	
Services	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	0%	Х	
Orthodontics	, ,	***	• •	

mber Cost Share	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil		CA Enh CSR Silver 8	
mber dost chare t	aniounio desaribo dio Enrolice o dat di podici cossis.	100%-150%	% FPL	150%-200% FPL	
tuarial Value - A\	/ Calculator	94.7% <u>95</u>	i.1%	88.8% <u>88.9%</u>	
	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	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$0 / \$0 / \$1,150		\$0 / \$0 / \$0 \$3,000	
	Family Out-of-pocket maximum			\$6,000	
	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	Deduc Appl
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or	Consisting visit	ФО.		#25	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tosts	Laboratory Tests Y-rays and Diagnostic Imaging	\$8		\$20 \$40	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Drugs to treat	Tier 2	\$10		\$25	
Drugs to treat illness or condition	Tier 3	\$15		\$45	
				υ+ υ	
	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%	
services	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention		Ψοσ		Ų. S	
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		20%	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
Mental		1070		2070	
nealth, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or	Mental/behavioral health and substance use disorder other outpatient	25			
substance abuse needs	items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%		20%	
nealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Ohild	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	140 Glaige		140 Glaige	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth Topical Fluoride Application				
	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental	Space Maintainers - Fixed Rectorative Procedures				
Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				

2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB Date: July 20, 2023 February 15, 2024

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 200%-250% FPL	
tuarial Value - A\	/ Calculator	70 50/, 79 10/.	
uanai value - Av	Plan design includes a deductible?	79.5% <u>78.1%</u> 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	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$30</u>	
Health care provider's	Other practitioner office visit	\$ 35 <u>\$30</u>	
office or clinic visit	Specialist visit	\$ 85 <u>\$75</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
Drugs to treat illness or condition	Tier 2	\$55	
	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 immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35 \$30	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	
,	Physician/surgeon fee	30%	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35 <u>\$30</u>	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35 <u>\$30</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$30</u>	
recovering or	Skilled nursing care	30%	
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	No charge	
and Preventive	Sealants per Tooth	Š	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	∠∪70	
	Crowns and Casts		
Child Destal	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
	- :=:0=:)		

9.5 EHB

Date: July 20, 2023 February 15, 2024

Summary of Benefits and Coverage



Individual-only Platinum Individual-only Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs Copay Plan Actuarial Value - AV Calculator 91.9% 90.7% <u>91.6%</u> Plan design includes a deductible? No \$0 \$0 Integrated Individual deductible 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 N/A HSA family plan: Individual deductible N/A Common **Member Cost** Deductible Applies Member Cost Deductible Applies Medical Service Type Event 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 \$15 Tests X-rays and Diagnostic Imaging \$30 \$30 Imaging (CT/PET scans, MRIs) 10% \$75 Tier 1 \$7 \$7 Tier 2 \$16 \$16 Drugs to treat condition Tier 3 \$25 \$25 10% up to \$250 per 10% up to \$250 per Tier 4 script script Surgery facility fee (e.g., ASC) 10% \$75 Outpatient services Physician/surgeon fees 10% \$20 Outpatient visit 10% 10% Emergency room facility fee (waived if admitted) \$150 Emergency room physician fee (waived if admitted) No charge No charge Medical transportation (including emergency and non-emergency) Need \$150 \$150 immediate Urgent care \$15 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) \$225 per day up to 5 days Hospital stay No charge Mental Mental/behavioral health and substance use disorder outpatient office \$15 \$15 health. visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance \$15 abuse needs Prenatal care and preconception visits No charge No charge Pregnancy Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$15 Help recovering or \$125 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 Eye exam No charge No charge Child eye 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic Not Covered Not Covered Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed **Child Dental** Not Covered Not Covered Periodontal Maintenance Services Services Crowns and Casts Endodontics **Child Dental** Periodontics (other than maintenance) Not Covered Not Covered Major Services Prosthodontics Oral Surgery Medically necessary orthodontics Not Covered Not Covered

2024 2025 Patient-Centered Benefit Plan Designs 9.5 EHB Date: July 20, 2023 February 15, 2024

•	amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	Ī	CCSB-onl Platinum Copay Pla	í
Actuarial Value - A\	V Calculator	91.2% <u>91.3</u>	<u>%</u>	89.4% <u>90.5</u>	<u>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	. ,		\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Toete	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat illness or condition	Tier 2	\$25		\$20	
	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
Need	Emergency room physician fee (waived if admitted)				
		No charge		No charge	
immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention	Urgent care	\$15		\$20	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	10% 10%		\$250 per day up to 5 days No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs				5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	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				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	Not Covered		INOL COVERED	
. 1076111176	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
33.71003	Crowns and Casts				
	Endodontics				
Child Dental		Not Covered		Not Covered	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Ohild	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2024 2025 Patient-Centered Benefit Plan Designs 9.5 EHB Date: July 20, 2023 February 15, 2024

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance I		Individual-only Copay Pla	
	V Onlandator	04.00/.04.50	N/	04.50/.04.0	•0/
tuarial Value - A\		81.9% <u>81.59</u>	<u>70</u>	81.5% <u>81.6</u>	<u>1%</u>
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0/\$0/\$	
	Individual Out-of-pocket maximum	\$8,700		\$8,700	
	Family Out-of-pocket maximum	\$17,400		\$17,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Dedu App
	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	•				
. 0313	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$60		\$60	
Ilness or condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%		\$130	
Outpatient	Physician/surgeon fees	30%		\$40 <u>\$60</u>	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350 \$330		\$350 \$330	
Need mmediate attention	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%		\$330 \$350 per day	
Hospital stay	Physician/surgeon fee	30%		up to 5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office			3	
health, behavioral health, or	visits	\$35		\$35	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
recovering or	Skilled nursing care	30%		\$150 per day up to	
other special health needs	Durable medical equipment	20%		5 days 20%	
	Hospice service	No charge		No charge	
	•	-		_	
Child eye care	1 pair of glasses per year (or contact langue in liquid glasses)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not Covers		Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dant-		l <u>.</u>		Nat Carrant	
	Periodontics (other than maintenance)	Not Covered		Not Covered	
Child Dental Major Services	,	Not Covered		Not Covered	
Major	Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	

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· · · · · · · · · · · · · · · · · · ·	nefits and Coverage	CCSB-only		CCSB-only		
-	amounts describe the Enrollee's out of pocket costs.	Gold		Gold		
Welliber Goot Gridie	unicanic decision in Emiliace 3 dat of poster code.	Coinsurance Pla	n	Copay Plan		
Actuarial Value - A\	/ Calculator	78.8% <u>79.1%</u>		80.7% <u>80.5%</u>		
Actuariai value - A	Plan design includes a deductible?					
	Integrated Individual deductible	N/A	acy	Yes, Medical/Pharr	пасу	
	Integrated Family deductible	N/A		N/A		
				N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0		
	Individual Out-of-pocket maximum	\$7,800		\$7,800		
	Family Out-of-pocket maximum			\$15,600		
	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	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care	Ou					
provider's office or	Other practitioner office visit	\$25		\$35		
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tooto	·					
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х	
	Tier 1	\$15		\$15		
Drugs to treat	Tier 2	\$50		\$40		
illness or condition	Tier 3	\$80		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%			X	
Outpatient				\$300	^	
services	Physician/surgeon fees	20%		\$35		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	20%	x	\$250	X	
immediate		20%	,	\$255	,	
attention	Urgent care	\$25		\$35		
	organic cure	ΨΣΟ		Ψ00		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X	\$600 per day up to 5 days	X	
Hospital stay	delivery, mental health, and substance use)				,	
	Physician/surgeon fee	20%	X	No charge		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$25		\$35		
behavioral	visits	Ψ20		Ψοσ		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	405		405		
abuse needs	items and services	\$25		\$35		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
Holo	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
Help recovering or			.,			
other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	X	
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	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		
501 VI063	Crowns and Casts					
	Endodontics					
Child Dental						
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		

9.5 EHB

Summary	, of	Renefite	and	Coverage
Sullilliaiv	<i>'</i> UI	Denenio	anu	Coverage

noer Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	rian
uarial Value - A\	V Calculator	71.8% <u>71.6%</u>	
	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	\$5,400 / \$150 <u>\$50</u> /	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$300 <u>\$100</u>	/ \$0
	Individual Out–of–pocket maximum Family Out-of-pocket maximum	\$ 9,100 <u>\$8,700</u>	
	HSA plan: Self-only coverage deductible	\$18,200 <u>\$17,400</u> N/A	_
	HSA family plan: Individual deductible	N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$50	
Health care	Other practitioner office visit	\$50	
orovider's office or	Other practitioner office visit	φου	
clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19 <u>\$18</u>	
Orugs to treat	Tier 2	\$60	Pharma deductik
liness or	Time	400	Pharma
condition	Tier 3	\$90	deductik
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductik
	Surgery facility fee (e.g., ASC)	30%	
Outpatient	Physician/surgeon fees	30%	
services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$450 \$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need		•	
mmediate	Medical transportation (including emergency and non-emergency)	\$250	
attention		450	
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	x
Hospital stay	delivery, mental health, and substance use)		,
	Physician/surgeon fee	30%	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
ehavioral nealth, or	VISIG		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
ecovering or	Skilled nursing care	30%	×
other special nealth needs			_ ^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
out 6	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	1101 0010100	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Net Course	
Basic Bervices	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental	Periodontics (other than maintenance)	Not Covered	
viajor	,	,,	
Major Services	Prosthodontics		
-	Prosthodontics Oral Surgery		

_	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plar	1	CCSB-only Silver Copay Plan	
	10.1.1.				
Actuarial Value - A\		70% 69.5%	201	69.7% 69.1% Yes, Medical/Pharm	201
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharma	асу	N/A	асу
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0)	\$2,500 / \$300 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0)	\$5,000 / \$600 / \$6	0
	Individual Out-of-pocket maximum	\$8,600		\$8,750	
	Family Out-of-pocket maximum			\$17,500	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common	TIGA family plan. Individual deductible	IVA		IVA	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care provider's	Other practitioner office visit	\$55		\$55	
office or	Consideration in	400		200	
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%	X	\$300	X
	Tier 1	\$20		\$19	
Drugo to to t	Tier 2	\$75	Pharmacy	\$85	Pharmacy
Drugs to treat illness or		Ų. S	deductible Pharmacy	·	deductible Pharmacy
condition	Tier 3	\$105	deductible	\$110	deductible
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	35%	Х	35%	Х
Outpatient services	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	х	35%	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	35%	x	35%	Х
immediate attention	Urgent care	\$55		\$55	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	35% 35%	x x	35% 35%	Χ
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$55		\$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
recovering or	Skilled nursing care	35%	x	35%	Х
other special health needs	Durable medical equipment	35%		35%	**
	Hospice service Eye exam	No charge		No charge	
Child eye care		No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Obild Day ()	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
20. 11003	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Date: July 20,	2023 February 15, 2024		
-	nefits and Coverage	CCSB-o	-
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	HDHP P	
Actuarial Value - A\	/ Calculator	71.7% <u>71</u>	20%
Actualiai Value - A	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$2,850 integ	
	Integrated Family deductible	\$5,700 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out–of–pocket maximum	\$7,500)
	Family Out-of-pocket maximum		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$2,850 See endr	
Common	•		
Medical Event	Service Type	Member Cost Share	Deductible Applies
	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	V
Tests	Laboratory Tests	25%	X
rests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25% 25% up to \$250 per	X
	Tier 1	script	X
Drugs to treat	Tier 2	25% up to \$250 per script	х
illness or condition	Tier 3	25% up to \$250 per	x
001141111011		script 25% up to \$250 per	
	Tier 4	script	X
	Surgery facility fee (e.g., ASC)	25%	Х
Outpatient services	Physician/surgeon fees	25%	х
	Outpatient visit	25%	Х
Need immediate	Emergency room facility fee (waived if admitted)	25%	Х
	Emergency room physician fee (waived if admitted)	0%	х
	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
поѕрна стау	Physician/surgeon fee	25%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office	05%	· ·
health, behavioral	visits	25%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient	25%	X
abuse needs	items and services	2070	^
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	X
Help	Outpatient Rehabilitation and Habilitation services	25%	X
recovering or other special	Skilled nursing care	25%	Х
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		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Dantal	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics	N=+ O	
Major Services	Periodontics (other than maintenance) Prosthodontics	Not Covered	
Child	Oral Surgery	N . O	
Orthodontics	Medically necessary orthodontics	Not Covered	

9.5 EHB

Summary of Benefits and Coverage	ę
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Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL	
Actuarial Value - A	V Calculator	94.9% <u>94</u>	. <u>7%</u>	87.9% <u>88.0%</u>	
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A	,	N/A	,
	Integrated Framily deductible	N/A		N/A	
			0 / 60		-0 / ¢0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 <u>\$0</u> / \$		\$800 <u>\$1,400</u> / \$50 <u>\$35</u>	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 <u>\$0</u> / \$		\$1,600 <u>2,800</u> / \$100 <u>\$7</u>	<u>'00</u> / \$0
	Individual Out–of–pocket maximum	\$1,150 <u>\$1</u>	<u>,300</u>	\$3,150 <u>\$3,050</u>	
	Family Out-of-pocket maximum	\$2,300 <u>\$2</u>	<u>2.600</u>	\$6,300 <u>\$6,100</u>	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or		**		*	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
		·			
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$6 \$8	
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
illness or condition	Tier 3	\$15		\$45	Pharmacy deductible
	Time	10% up to \$150 per		450/ 4 4450	Pharmacy
	Tier 4	script		15% up to \$150 per script	deductible
Outpatient	Surgery facility fee (e.g., ASC)	10%		20%	
services	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	
Need	Medical transportation (including emergency and non-emergency)	_		\$75	
immediate	wedical transportation (including emergency and non-emergency)	\$30		\$75	
attention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100/	V	300/	
Hospital stay	delivery, mental health, and substance use)	10%	X	20%	X
	Physician/surgeon fee	10%		20%	
Mental	Mental/behavioral health and substance use disorder outpatient office	¢=		\$15	
health, behavioral	visits	\$5		\$15	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or			v	·	
other special health needs	Skilled nursing care	10%	X	20%	X
nearth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	90			
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	11 2375.04		0,0,04	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
Get Alces	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
55.71005	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

ember Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL		
tuarial Value - A		74.0% 73.9%		
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm	iacy	
	Integrated Family deductible	N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / \$150 <u>\$350</u>	/ \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$300 <u>\$700</u>	/ \$0	
	Individual Out-of-pocket maximum	\$7,550 <u>\$7,350</u>		
	Family Out-of-pocket maximum	\$15,100 <u>\$14,700</u>	<u>)</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Lvent	Primary care visit to treat an injury, illness, or condition	\$50 <u>\$35</u>		
Health care provider's	Other practitioner office visit	\$50		
office or		_		
clinic visit	Specialist visit	\$90 <u>\$85</u>		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$50 \$05		
16313	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$95 \$325		
		\$325		
	Tier 1	\$19		
Drugs to treat	Tier 2	\$55	Pharmad deductible	
illness or condition	Tier 3	\$85	Pharma	
oonanion			deductib	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib	
	Surgery facility fee (e.g., ASC)	30%		
Outpatient services	Physician/surgeon fees	30%		
	Outpatient visit	30%		
	Emergency room facility fee (waived if admitted)	\$450 \$350		
	Emergency room physician fee (waived if admitted)	No charge		
Need immediate	Medical transportation (including emergency and non-emergency)	\$250		
attention				
	Urgent care	\$50 \$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	х	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%		
Mental	Mental/behavioral health and substance use disorder outpatient office	¢50 ¢25		
health, behavioral	visits	\$50		
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$50 <u>\$35</u>		
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$40		
Help	Outpatient Rehabilitation and Habilitation services	\$50		
recovering or	Skilled nursing care	30%	Х	
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			
and	Sealants per Tooth	Not Covered		
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
Child Day	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	Not Covered		

9.5 EHB

Summary	of	Benefits	and	Coverage
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Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze HDHP Plan	
ctuarial Value - AV Calculator		64.4% <u>63.7%</u>		64.9%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, integrat	ted
Integrated Individual deductible		N/A	•	\$7,050 \$6,650 integrated	
Integrated Family deductible		N/A		\$14,100 <u>\$13,300</u> ir	ntegrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$ 6,300 <u>\$5,800</u> / \$ 500 <u>\$</u>	3 <mark>450</mark> / \$0	N/A	J
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,600 \$11,600 / \$1,000		N/A	
	Individual Out-of-pocket maximum	\$9,100 \$8,850		\$7,050 \$6,650	
	Family Out-of-pocket maximum	\$ 18,200 \$17,70		\$14,100 \$13,	
	HSA plan: Self-only coverage deductible	N/A		\$7,050 \$6,6	
	HSA family plan: Individual deductible	N/A		\$7,050 \$6,6	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$60	After 1st three non-	0%	Х
Health care			preventive visits After 1st three non-		
provider's office or	Other practitioner office visit	\$60	preventive visits	0%	X
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge	
	Laboratory Tests	\$40		0%	X
Toots	,		V		
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	Х
	Tier 1	\$17 \$19	Pharmacy Deductible	0%	X
Druge to to	Tier 2	40% up to \$500 per script after	Pharmacy	0%	×
Drugs to treat illness or		pharmacy deductible	Deductible	7 /0	
condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Time	40% up to \$500 per script after	Pharmacy		
	Tier 4	pharmacy deductible	Deductible	0%	Х
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient services	Physician/surgeon fees	40%	X	0%	Х
	Outpatient visit	40%	X	0%	X
	Emergency room facility fee (waived if admitted)	40%	x	0%	x
			^		
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need immediate	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
attention	Urgent care	\$60	After 1st three non- preventive visits	0%	×
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	×	0%	x
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	40%	X	0%	X
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient	\$60		0%	x
substance abuse needs	items and services	\$60		0%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	x
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	x
recovering or	Skilled nursing care	40%	×	0%	×
other special health needs					
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	Х
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental					
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
				N . 0	
Child Dental	Llargedenties (other than maintenance)	Not Covered		Not Covered	
Child Dental Major Services	Periodontics (other than maintenance)				
Major	Prosthodontics				
Major	·				

9.5 EHB

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Catastrophic Plan				
Actuarial Value - A	V Calculator			
	Plan design includes a deductible?	Yes,	integrated	
	Integrated Individual deductible		0,200 integrated	
	Integrated Family deductible	\$18,900 <u>\$1</u>	8,400 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
	Individual Out-of-pocket maximum	\$ 9. 4	50 \$9,200	
	Family Out-of-pocket maximum		00 \$18,400	
	HSA plan: Self-only coverage deductible		N/A	
	HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Event	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits	
Health care provider's	Other practitioner office visit	0%	After 1st three non- preventive visits	
office or clinic visit	Specialist visit	0%	x	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	0%	x	
Tests	X-rays and Diagnostic Imaging	0%	×	
	Imaging (CT/PET scans, MRIs)	0%	×	
	Tier 1	0%	х	
Drugs to treat illness or	Tier 2	0%	X	
condition	Tier 3	0%	Х	
	Tier 4	0%	X	
	C	00/	V	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	0%	X	
services	Outpatient visit	0%	X X	
	Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	No charge	^	
Need	Medical transportation (including emergency and non-emergency)	0%	X	
immediate attention	medical state of the state of t	070	^	
attention	Urgent care	0%	After 1st three non-	
			preventive visits	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	x	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	X	
Mental	Mental/behavioral health and substance use disorder outpatient office	070	After 1st three non-	
health, behavioral	visits	0%	preventive visits	
health, or	Mental/behavioral health and substance use disorder other outpatient			
substance abuse needs	items and services	0%	Х	
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	0%	x	
Help	Outpatient Rehabilitation and Habilitation services	0%	Х	
recovering or other special	Skilled nursing care	0%	Х	
health needs	Durable medical equipment	0%	Х	
	Hospice service	0%	Х	
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х	
	Oral Exam			
01.11.1	Preventive - Cleaning			
Child Dental Diagnostic	Preventive - X-ray	Not Covered		
and Preventive	Sealants per Tooth	Not Covered		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services	, to: Oovereu		
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	Not Covered		
30.11003	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics	Not Covered		

2024 2025 Patient-Centered Benefit Plan Designs 9.5 EHB Date: July 20, 2023 February 15, 2024

lember Cost Share amounts describe the Enrollee's out of pocket costs.		CA Enh CSR Silver 94 Plan 100%-150% FPL		CA Enh CSR Silver 87 Plan 150%-200% FPL		
	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 HSA family plan: Individual deductible	N/A N/A		N/A N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie	
Event	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
Health care provider's	Other practitioner office visit	\$5		\$15		
office or						
clinic 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		
rugs to treat	Tier 2	\$10		\$25		
Iness or ondition	Tier 3	\$15		\$45		
ondition	nd o			ΨΨΟ		
	Tier 4	10% up to \$150 per script		15% up to \$150 per script		
	Surgery facility fee (e.g., ASC)	10%		20%		
Outpatient ervices	Physician/surgeon fees	10%		20%		
ei vices	Outpatient visit	10%		20%		
	Emergency room facility fee (waived if admitted)	\$50		\$150		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75		
mmediate	medical transportation (including emergency and non-emergency)	φ30		φισ		
attention	Urgent care	\$5		\$15		
Jacobital atou	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%		
lospital stay	Physician/surgeon fee	10%		20%		
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15		
pehavioral nealth, or						
substance abuse 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 other special	Skilled nursing care	10%		20%		
nealth needs	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
Nh:II d	Eye exam	No charge		No charge		
child eye are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	No charge		No charge		
hild Dental	Preventive - Cleaning					
Diagnostic nd	Preventive - X-ray	Not Covered		Not Covered		
reventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Services			23.0.00		
	Crowns and Casts					
Child Donts!	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	Not Covered		Not Covered		

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Plan 200%-250% FPL		
tuarial Value - A\	/ Calculator	79.5% <u>78.1%</u>		
luariai value - Av	Plan design includes a deductible?	79.9% <u>76.1%</u> 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	Deductik Applies	
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$30</u>		
Health care provider's	Other practitioner office visit	\$35 <u>\$30</u>		
office or clinic visit	Specialist visit	\$85 <u>\$75</u>		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$50		
Tests	X-rays and Diagnostic Imaging	\$95		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$15		
Drugs to treat	Tier 2	\$55		
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 .\$30		
	-			
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%		
	Physician/surgeon fee	30%		
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35 <u>\$30</u>		
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35 <u>\$30</u>		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$40		
Help	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$30</u>		
recovering or	Skilled nursing care	30%		
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	23.0.00		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
Child Dont	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			
	-·-·· >···g···,			

Endnotes to Covered California 2024-2025 Patient-Centered Benefit Plan Designs

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

Notes:

- 1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2024-2025 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) Where indicated, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, and/or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2024 2025 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, Podiatrists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit

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

Tier	Definition
1	Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs;
2	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.
	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based
3	on drug safety, efficacy and cost or;
	Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and
	Drug Administration (FDA) or drug manufacturer requires to
	be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or
	clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than
	six hundred dollars (\$600) net of rebates for a one-month
	supply.

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The 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 2024 2025 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.
- 32) These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.