Covered California 2024 Patient-Centered Benefit Plan Designs¹

Final Board-approved May 18, 2023

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

Prosthodontics Oral Surgery

Medically necessary orthodontics

Child

Summary of Benefits and Coverage



al-only Platinum Individual-only Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copav Plan Actuarial Value - AV Calculator 91.9% 90.7% Plan design includes a deductible? No No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$4,500 Individual Out-of-pocket maximum \$4,500 Family Out-of-pocket maximum \$9,000 \$9,000 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Commor Member Cost Member Cost Deductible Applies Deductible Applies Service Type Medical Sha Sha Event Primary care visit to treat an injury, illness, or condition \$15 \$15 Health care provider's office or Other practitioner office visit \$15 \$15 clinic visit Specialist visit \$30 \$30 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$15 \$15 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 illnes or condition Tier 3 \$25 \$25 10% up to \$250 per 10% up to \$250 per Tier 4 . script script Surgery facility fee (e.g., ASC) \$75 10% Outpatient services Physician/surgeon fees 10% \$20 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 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:starses}$ \$225 per day up to 5 days 10% Hospital stay Physician/surgeon fee 10% No charge Mental Mental/behavioral health and substance use disorder outpatient office \$15 \$15 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance \$15 \$15 abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$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 No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge No charge and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures See 2024 Dental 20% Basic Copay Schedule Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental See 2024 Dental Periodontics (other than maintenance) Major 50% Copay Schedule Services

50%

\$1.000

CCSB-only Summary of Benefits and Coverage CCSB-only Platinum Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 91.2% 89.4% 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 \$4,500 Individual Out-of-pocket maximum \$4,500 Family Out-of-pocket maximum \$9,000 \$9,000 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Member Cost Member Cost Deductible Applies Deductible Applies Service Type Medical Sha Sha Event Primary care visit to treat an injury, illness, or condition \$15 \$20 Health care provider's office or Other practitioner office visit \$15 \$20 clinic visit Specialist visit \$30 \$30 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$15 \$20 Tests X-rays and Diagnostic Imaging \$30 \$30 Imaging (CT/PET scans, MRIs) 10% \$100 Tier 1 \$5 \$10 Tier 2 \$25 \$20 Drugs to treat illnes or condition Tier 3 \$40 \$30 10% up to \$250 per 10% up to \$250 per Tier 4 . script script Surgery facility fee (e.g., ASC) \$100 10% Outpatient services Physician/surgeon fees 10% \$25 Outpatient visit 10% 10% Emergency room facility fee (waived if admitted) \$200 \$150 Emergency room physician fee (waived if admitted) No charge No charge Need Medical transportation (including emergency and non-emergency) \$150 \$150 immediate attention Urgent care \$15 \$20 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:starses}$ \$250 per day up to 5 days 10% Hospital stay Physician/surgeon fee 10% No charge Mental Mental/behavioral health and substance use disorder outpatient office \$15 \$20 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance \$15 \$20 abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$20 Help recovering or \$150 per day up to Skilled nursing care 10% other special health needs 5 days Durable medical equipment 10% 10% Hospice service No charge No charge No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge No charge and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures See 2024 Dental 20% Basic Copay Schedule Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental See 2024 Dental Periodontics (other than maintenance) Major 50% Copay Schedule Services Prosthodontics Oral Surgery

50%

\$1.000

Child

Medically necessary orthodontics

mber Cost Share amounts describe the Enrollee's out of pocket costs.		Individual-only Gold Coinsurance Plan		Individual-only Gold Copay Plan		
tuarial Value -	AV Calculator	81.9%		81.5%		
	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	\$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 Nedical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie	
1	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		
ests	X-rays and Diagnostic Imaging	\$75		\$75		
	Imaging (CT/PET scans, MRIs)	25%		\$75		
	Tier 1	\$15		\$15		
Drugs to	Tier 2	\$60		\$60		
reat illness or condition	Tier 3	\$85		\$85		
	Tier 4	20% up to \$250 per		20% up to \$250 per		
	Surgery facility fee (e.g., ASC)	script		script \$130		
Outpatient						
services	Physician/surgeon fees	30%		\$40		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	\$350		\$350		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250		
mmediate attention						
	Urgent care	\$35		\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$330 per day up to		
Hospital stay	delivery montal health, and substance use)	30%		5 days		
	Physician/surgeon fee	30%		No charge		
Vental	Mental/behavioral health and substance use disorder outpatient office					
nealth, behavioral	visits	\$35		\$35		
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35		
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge		
J	Home health care (cost share per visit)	20%		\$30		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35		\$35 \$150 per day up to		
other special	Skilled nursing care	30%		5 days		
nealth needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
are	- 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam			in the go		
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			See 2024 Dental		
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule		
	Crowns and Casts					
Child Dental	Endodontics			See 2024 Dental		
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule		
	Prosthodontics					
	Oral Surgery					
Child						

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Pla	n	CCSB-only Gold Copay Plan	
uarial Value - A'		78.8%		80.7%	
uariai value - A	V Calculator Plan design includes a deductible?	78.8% Yes, Medical/Pharma	2014	Yes, Medical/Phar	2004
	Integrated Individual deductible	N/A	acy	N/A	пасу
	Integrated Harviddal deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out–of–pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
_vent	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care					
orovider's office or	Other practitioner office visit	\$25		\$35	
clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	x
					~
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$50		\$40	
reat illness					
or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	х
Outpatient	Physician/surgeon fees				~
services		20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	Х	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	Х	\$250	х
immediate attention					
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		×		
Hospital stay	delivery, mental health, and substance use)	20%	Х	\$600 per day up to 5 days	Х
	Physician/surgeon fee	20%	Х	No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$25		\$35	
behavioral	visits	ψ 2 0			
health, or substance	Mental/behavioral health and substance use disorder other outpatient	¢oc		\$35	
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	
Holp	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
Help recovering or			v		
other special health needs	Skilled nursing care	20%	Х	\$300 per day up to 5 days	Х
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive					
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2024 Dental Copay	
Services	Periodontal Maintenance Services	2070		Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2024 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child					
Child	Medically necessary orthodontics	50%		\$1,000	

2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 18, 2023 Summary of Benefits and Coverage

Child Orthod

Medically necessary orthodontics

Member Cost Share amounts describe the Enrollee's out of pocket costs. Individual-only Silver Plan Actuarial Value - AV Calculator 71.8% Plan design includes a deductible? Yes, Medical/Pharmacy Integrated Individual deductible N/A Integrated Family deductible N/A \$5,400 / \$150 / \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental \$10,800 / \$300 / \$0 Individual Out-of-pocket maximum \$9,100 Family Out-of-pocket maximum \$18,200 HSA plan: Self-only coverage deductible N/A HSA family plan: Individual deductible N/A Common Deductible Applies Service Type Member Cost Share Medical Event Primary care visit to treat an injury, illness, or condition \$50 Health care provider's office or Other practitioner office visit \$50 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 Pharmacy deductible Tier 2 \$60 Drugs to treat illnes Pharmacy or condition Tier 3 \$90 deductible 20% up to \$250 per script Pharmacy Tier 4 after pharmacy deductible deductible Surgery facility fee (e.g., ASC) 30% Outpatient services Physician/surgeon fees 30% Outpatient visit 30% Emergency room facility fee (waived if admitted) \$450 Emergency room physician fee (waived if admitted) No charge Need Medical transportation (including emergency and non-emergency) \$250 immediate attention Urgent care \$50 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:starses}$ 30% Х Hospital stay Physician/surgeon fee 30% Mental Mental/behavioral health and substance use disorder outpatient office \$50 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance \$50 abuse needs Prenatal care and preconception visits Pregnancy No charge Home health care (cost share per visit) \$45 Outpatient Rehabilitation and Habilitation services \$50 Help recovering or Skilled nursing care 30% Х other special health needs Durable medical equipment 20% Hospice service No charge No charge Eye exam Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures 20% Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) 50% Major Services Prosthodontics Oral Surgery

50%

Child

Medically necessary orthodontics

Summary of Benefits and Coverage CCSB-only CCSB-only Silver Silver Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 70.0% 69.7% Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy Integrated Individual deductible N/A N/A Integrated Family deductible N/A N/A \$2,500 / \$300 / \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$2,500 / \$300 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$5,000 / \$600 / \$0 \$5,000 / \$600 / \$0 Individual Out-of-pocket maximum \$8,750 \$8,600 Family Out-of-pocket maximum \$17,200 \$17,500 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Deductible Applies Deductible Service Type Member Cost Share Member Cost Share Medical Event Primary care visit to treat an injury, illness, or condition \$55 \$55 Health care provider's Other practitioner office visit \$55 \$55 office or clinic visit Specialist visit \$90 \$90 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$55 \$55 Tests X-rays and Diagnostic Imaging \$90 \$90 Imaging (CT/PET scans, MRIs) 35% х \$300 х Tier 1 \$20 \$19 Pharmacy deductible Pharmacy deductible Tier 2 \$75 \$85 Drugs to treat illne Pharmacy Pharmacy or condition Tier 3 \$105 \$110 deductible deductible 30% up to \$250 per script after Pharmacy 30% up to \$250 per script after Pharmacy Tier 4 pharmacy deductible deductible pharmacy deductible 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% 35% х х immediate attention Urgent care \$55 \$55 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:starses}$ 35% Х 35% Х Hospital stay Physician/surgeon fee 35% 35% Mental Mental/behavioral health and substance use disorder outpatient office \$55 \$55 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient substance \$55 \$55 items and services abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 35% \$45 Outpatient Rehabilitation and Habilitation services \$55 \$55 Help recovering or Skilled nursing care 35% х 35% х other special health needs Durable medical equipment 35% 35% Hospice service No charge No charge Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge No charge and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures See 2024 Dental Copay Basic Services 20% Schedule Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental See 2024 Dental Copay Periodontics (other than maintenance) Major 50% Schedule Services Prosthodontics Oral Surgery

50%

\$1.000

Child Ortho

Medically necessary orthodontics

50%

CCSB-only Summary of Benefits and Coverage Silver Member Cost Share amounts describe the Enrollee's out of pocket costs. HDHP Plan Actuarial Value - AV Calculator 71.7% Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2,850 integrated Integrated Family deductible \$5,700 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A Individual Out-of-pocket maximum \$7,500 Family Out-of-pocket maximum \$15,000 HSA plan: Self-only coverage deductible \$2.850 HSA family plan: Individual deductible See endnote Common Service Type Member Cost Share Deductible Applie Medical Event Primary care visit to treat an injury, illness, or condition 25% х Health care provider's Other practitioner office visit 25% х office or clinic visit Specialist visit 25% х Preventive care/ screening/ immunization No charge 25% Laboratory Tests Х Tests X-rays and Diagnostic Imaging 25% х Imaging (CT/PET scans, MRIs) 25% Х 25% up to \$250 per Tier 1 Х script 25% up to \$250 per Tier 2 х Drugs to treat illnes script 25% up to \$250 per or condition Tier 3 Х script 25% up to \$250 per Tier 4 x script Surgery facility fee (e.g., ASC) 25% Х Outpatient services Physician/surgeon fees 25% х Outpatient visit 25% Х Emergency room facility fee (waived if admitted) 25% Х Emergency room physician fee (waived if admitted) 0% х Need Medical transportation (including emergency and non-emergency) 25% х immediate attention Urgent care 25% х Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:facility}$ 25% Х Hospital stay 25% Physician/surgeon fee х Mental Mental/behavioral health and substance use disorder outpatient office 25% Х health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance 25% Х abuse needs Prenatal care and preconception visits Pregnancy No charge Home health care (cost share per visit) 25% х Outpatient Rehabilitation and Habilitation services 25% х Help recovering or Skilled nursing care 25% Х other special health needs Durable medical equipment 25% Х Hospice service 0% х No charge Eye exam Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures Basic Services 20% Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) Major 50% Services Prosthodontics Oral Surgery

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPL	-
tuarial Value - A	V Calculator	94.9%	5	87.9%	
	Plan design includes a deductible?	Yes, Medical/F		Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$800 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/ \$0	\$1,600 / \$100 / \$	0
	Individual Out–of–pocket maximum	\$1,150)	\$3,150	
	Family Out-of-pocket maximum	\$2,300)	\$6,300	
	HSA plan: Self-only coverage deductible	N/A N/A		N/A N/A	
Common	HSA family plan: Individual deductible	Member Cost	Deductible		Deductib
Medical Event	Service Type	Share	Applies	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
provider's	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	
					Pharma
Drugs to	Tier 2	\$10		\$25	deductib
treat illness or condition	Tier 3	\$15		\$45	Pharma deductib
	Tier 4	10% up to \$150 per		15% up to \$150 per script	Pharma
_	Surgery facility fee (e.g., ASC)	script		20%	deductib
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 immediate	Medical transportation (including emergency and non-emergency)	\$30		\$75	
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	Х	20%	x
Hospital stay	delivery, mental health, and substance use)		X		
Maria	Physician/surgeon fee	10%		20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%	х	20%	x
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
		_		-	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth			-	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
Services					
	Oral Surgery				

2024 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 18, 2023 Summary of Benefits and Coverage

Child Orthod

Medically necessary orthodontics

Silver Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. 200%-250% FPL Actuarial Value - AV Calculator 74.0% Plan design includes a deductible? Yes, Medical/Pharmacy Integrated Individual deductible N/A Integrated Family deductible N/A \$5,400 / \$150 / \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental \$10,800 / \$300 / \$0 Individual Out–of–pocket maximum \$7,550 Family Out-of-pocket maximum \$15,100 HSA plan: Self-only coverage deductible N/A HSA family plan: Individual deductible N/A Common Deductible Applies Member Cost Share Service Type Medical Event Primary care visit to treat an injury, illness, or condition \$50 Health care provider's office or Other practitioner office visit \$50 clinic visit Specialist visit \$90 Preventive care/ screening/ immunization No charge \$50 Laboratory Tests Tests X-rays and Diagnostic Imaging \$95 Imaging (CT/PET scans, MRIs) \$325 Tier 1 \$19 Pharmacy deductible Tier 2 \$55 Drugs to treat illnes Pharmacy or condition Tier 3 \$85 deductible 20% up to \$250 per script Pharmacy Tier 4 after pharmacy deductible deductible Surgery facility fee (e.g., ASC) 30% Outpatient services Physician/surgeon fees 30% Outpatient visit 30% Emergency room facility fee (waived if admitted) \$450 Emergency room physician fee (waived if admitted) No charge Need Medical transportation (including emergency and non-emergency) \$250 immediate attention Urgent care \$50 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:constraint}$ 30% Х Hospital stay 30% Physician/surgeon fee Mental Mental/behavioral health and substance use disorder outpatient office \$50 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance \$50 abuse needs Prenatal care and preconception visits Pregnancy No charge Home health care (cost share per visit) \$40 Outpatient Rehabilitation and Habilitation services \$50 Help recovering or Skilled nursing care 30% Х other special health needs Durable medical equipment 20% Hospice service No charge No charge Eye exam Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures Basic Services 20% Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) 50% Major Services Prosthodontics Oral Surgery

50%

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plar	n
uarial Value - A	V Calculator	64.4%		64.9%	
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integrat	red
	•		nacy	_	
	Integrated Individual deductible	N/A		\$7,050 integra	
	Integrated Family deductible	N/A		\$14,100 integra	ated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$		N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 /	/ \$0	N/A	
	Individual Out–of–pocket maximum	\$9,100		\$7,050	
	Family Out-of-pocket maximum	\$18,200		\$14,100	
	HSA plan: Self-only coverage deductible	N/A		\$7,050	
-	HSA family plan: Individual deductible	N/A		\$7,050	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$60	After 1st three non- preventive visits	0%	х
lealth care provider's	Other practitioner office visit	\$60	After 1st three non-	0%	x
office or		<i>400</i>	preventive visits	0,0	~
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	Х
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	х
fests	X-rays and Diagnostic Imaging	40%	X	0%	Х
	Imaging (CT/PET scans, MRIs)	40%	x	0%	х
	Tier 1	\$17	Pharmacy Deductible	0%	x
			namacy Deductible	U 76	~
Drugs to	Tier 2	40% up to \$500 per script after	Pharmacy	0%	x
reat illness		pharmacy deductible	Deductible		
or condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
	Surgery facility fee (e.g., ASC)	40%	x	0%	х
Dutpatient					
ervices	Physician/surgeon fees	40%	X	0%	Х
	Outpatient visit	40%	x	0%	Х
	Emergency room facility fee (waived if admitted)	40%	x	0%	х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need mmediate attention	Medical transportation (including emergency and non-emergency)	40%	X	0%	х
	Urgent care	\$60	After 1st three non- preventive visits	0%	х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	x	0%	х
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	40%	Х	0%	Х
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient 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
lelp	Outpatient Rehabilitation and Habilitation services	\$60		0%	X
ecovering or other special	Skilled nursing care	40%	x	0%	х
health needs	Durable medical equipment	40%	x	0%	x
	Hospice service	No charge		0%	Х
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No chorao		No charge	
ind	Sealants per Tooth	No charge		no charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
bei vices					
	Crowns and Casts				
Child Dentel	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services		0070		0070	
	Prosthodontics				
	1				
	Oral Surgery				

			rophic Plan
tuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$9,45	0 integrated
	Integrated Family deductible	\$18,90	00 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	:	\$9,450
	Family Out-of-pocket maximum	\$	18,900
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
Lvein	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three no
office or			preventive visits
clinic visit	Specialist visit	0%	x
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	х
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	x
		0 /0	^
	Tier 1	0%	Х
	Tier 2	0%	x
Drugs to treat illness		070	^
or condition	Tier 3	0%	х
	Tim 4		
	Tier 4	0%	Х
	Surgery facility fee (e.g., ASC)	0%	х
Outpatient	Physician/surgeon fees	0%	x
services			
	Outpatient visit	0%	Х
	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%	х
immediate attention			
	Urgent care	0%	After 1st three no
	, , , , , , , , , , , , , , , , , , ,		preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	0%	х
,	Physician/surgeon fee	0%	х
Mental	Mental/behavioral health and substance use disorder outpatient office		After 1st three no
health,	visits	0%	preventive visits
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	х
Pregnancy	Prenatal care and preconception visits	No charge	
<u> </u>	Home health care (cost share per visit)	0%	х
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
	Eye exam	No charge	
Child eye care		-	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
01.11.1.5	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	х
Services	Periodontal Maintenance Services		
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	0%	х
Major Services		U 70	^
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics		х

Summary of Benefits and Coverage

Child

Medically necessary orthodontics

I-only Platinum Individual-only Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 91.9% 90.7% Plan design includes a deductible? No No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$4,500 Individual Out-of-pocket maximum \$4,500 Family Out-of-pocket maximum \$9,000 \$9,000 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Commor Member Cost Member Cost Deductible Applies Deductible Applies Service Type Medical Sha Sha Event Primary care visit to treat an injury, illness, or condition \$15 \$15 Health care provider's office or Other practitioner office visit \$15 \$15 clinic visit Specialist visit \$30 \$30 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$15 \$15 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 illnes or condition Tier 3 \$25 \$25 10% up to \$250 per 10% up to \$250 per Tier 4 . script script Surgery facility fee (e.g., ASC) \$75 10% Outpatient services Physician/surgeon fees 10% \$20 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 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:starses}$ \$225 per day up to 5 days 10% Hospital stay Physician/surgeon fee 10% No charge Mental Mental/behavioral health and substance use disorder outpatient office \$15 \$15 health, visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance \$15 \$15 abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$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 No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic Not Covered Not Covered and Sealants per Tooth Preventive **Topical Fluoride Application** Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Not Covered Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) Not Covered Major Not Covered Services Prosthodontics Oral Surgery

Not Covered

Not Covered

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB-only Platinum Coinsurance Plan		CCSB-only Platinum Copay Plan		
tuarial Value - A	V Calculator	91.2%		00.40		
tuarial value - A				89.4%		
Plan design includes a deductible?		No		No		
	Integrated Individual deductible	\$0		\$0		
	Integrated Family deductible	\$0 \$0 / \$0 / \$	0	\$0 \$0 (\$0 (\$	0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental			\$0 / \$0 / \$		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0	
	'			\$4,500		
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible			\$9,000 N/A		
	HSA family plan: Individual deductible			N/A		
Common Medical	Service Type	Member Cost	Deductible	Member Cost	Deducti	
Event	Primary care visit to treat an injury, illness, or condition	Share \$15	Applies	Share \$20	Applie	
Health care		φ15		ψ20		
provider's	Other practitioner office visit	\$15		\$20		
office or clinic visit	Specialist visit	\$30		\$30		
	Preventive care/ screening/ immunization	No charge		No charge		
-	-	-		-		
Footo	Laboratory Tests	\$15 \$20		\$20		
Fests	X-rays and Diagnostic Imaging	\$30		\$30		
	Imaging (CT/PET scans, MRIs)	10%		\$100		
	Tier 1	\$10		\$5		
	Tier 2	\$25		\$20		
Drugs to reat illness		φZO		φ∠∪		
or condition	Tier 3	\$40		\$30		
	Tier 4	10% up to \$250 per script		10% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	10%		\$100		
Outpatient	Physician/surgeon fees					
services		10%		\$25		
	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$200		\$150		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need mmediate	Medical transportation (including emergency and non-emergency)	\$150		\$150		
attention	Urgent care	\$15		\$20		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$250 per day up to		
Hospital stay	delivery, mental health, and substance use)	10%		5 days		
	Physician/surgeon fee	10%		No charge		
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20		
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20		
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	10%		\$20		
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20		
ecovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days		
nealth needs	Durable medical equipment	10%		10%		
	Hospice service	No charge		No charge		
Child are	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	-		-		
		No charge		No charge		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
and Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic	Periodontal Maintenance Services	Not Covered		Not Covered		
Services						
	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
00111003	Prosthodontics					
	Oral Surgery					

ember Cost Share amounts describe the Enrollee's out of pocket costs.		Coinsurance Plan		Copay Plan		
tuarial Value - A'	V Calculator	81.9%		81.5%		
	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	\$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	Deduct Applie	
laakk aana	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		
Fests	X-rays and Diagnostic Imaging	\$75		\$75		
	Imaging (CT/PET scans, MRIs)	25%		\$75		
	Tier 1	\$15		\$15		
Drugs to	Tier 2	\$60		\$60		
reat illness	Tier 3	\$85		\$85		
	Tier 4	20% up to \$250 per		20% up to \$250 per		
		script		script		
Outpatient	Surgery facility fee (e.g., ASC)	30%		\$130		
services	Physician/surgeon fees	30%		\$40		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	\$350		\$350		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250		
mmediate						
	Urgent care	\$35		\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$330 per day up to		
Hospital stay	delivery, mental health, and substance use)	30%		5 days		
	Physician/surgeon fee	30%		No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office	#0-		A 05		
nealth, behavioral	visits	\$35		\$35		
nealth, or 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		
lain	Outpatient Rehabilitation and Habilitation services	\$35		\$35		
lelp ecovering or				\$150 per day up to		
other special nealth needs	Skilled nursing care	30%		5 days		
icanii neeus	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics					
	Oral Surgery					

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold	n	CCSB-only Gold Conav Plan		
		Coinsurance Pla		Copay Plan		
tuarial Value - A		78.8%		80.7%		
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	Yes, Medical/Pharmacy		
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0		
	Individual Out–of–pocket maximum	\$7,800		\$7,800		
	Family Out-of-pocket maximum	\$15,600		\$15,600		
	HSA plan: Self-only coverage deductible	N/A		N/A		
Common	HSA family plan: Individual deductible	N/A		N/A		
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care	Other practitioner office visit	\$25		\$35		
provider's office or		ψ£ΰ		ψου		
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	х	
	Tier 1	\$15		\$15		
	Tier 2	\$50		\$40		
Drugs to treat illness						
or condition	Tier 3	\$80		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300	х	
Outpatient	Physician/surgeon fees	20%		\$35		
services	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	x	\$250	х	
	Emergency room physician fee (waived if admitted)	No charge	~	No charge	X	
Naad		-		_		
Need immediate	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х	
attention	Urgent care	\$25		\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	x	\$600 per day up to 5 days	х	
Hospital stay	Physician/surgeon fee	20%	x	No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office					
health, behavioral	visits	\$25		\$35		
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35		
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
other special	Skilled nursing care	20%	x	\$300 per day up to 5 days	Х	
health needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic and		Not Covered		Not Covered		
Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Services	101 001010		10100000		
	Crowns and Casts					
	Endodontics					
Child Dental		Not Covered		Not Covered		
	Periodontics (other than maintenance)					
Major						
Major Services	Periodontics (other than maintenance) Prosthodontics Oral Surgery					

Summary of Benefits and Coverage

tuarial Value - A'	V Calculator	71.8%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / \$150 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$300 / \$	50
	Individual Out-of-pocket maximum	\$9,100	
	Family Out-of-pocket maximum	\$18,200	
	HSA plan: Self-only coverage deductible	N/A N/A	
Common	HSA family plan: Individual deductible	N/A	
Medical Event	Service Type	Member Cost Share	Deductibl 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	
Drugs to	Tier 2	\$60	Pharmao deductibl
treat illness or condition	Tier 3	\$90	Pharmad
	Tier 4	20% up to \$250 per script	deductibl Pharmad
_	Surgery facility fee (e.g., ASC)	after pharmacy deductible	deductibl
Outpatient			
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$450	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	x
Hospital stay	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$50	
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits Home health care (cost share per visit)	No charge \$45	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$50	
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	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB-only Silver Coinsurance Plan		CCSB-only Silver Copay Plan		
	V Coloridator					
uarial Value - A	V Calculator Plan design includes a deductible?	70.0% Yes, Medical/Pharma	201	69.7% Vas Medical/Pharm	201	
	Integrated Individual deductible	N/A	icy	Yes, Medical/Pharmacy N/A		
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0		\$2,500 / \$300 / \$0)	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$0)	
	Individual Out–of–pocket maximum	\$8,600		\$8,750		
	Family Out-of-pocket maximum	\$17,200		\$17,500		
	HSA plan: Self-only coverage deductible			N/A		
Common	HSA family plan: Individual deductible	N/A		N/A		
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductik 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						
linic visit	Specialist visit	\$90		\$90		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$55		\$55		
ests	X-rays and Diagnostic Imaging	\$90		\$90		
	Imaging (CT/PET scans, MRIs)	35%	х	\$300	х	
	Tier 1	\$20		\$19		
	Ting 0		Pharmacy		Pharm	
Drugs to reat illness	Tier 2	\$75	deductible	\$85	deducti	
or condition	Tier 3	\$105	Pharmacy deductible	\$110	Pharm deduct	
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharm	
		pharmacy deductible	deductible	pharmacy deductible	deduct	
	Surgery facility fee (e.g., ASC)	35%	Х	35%	Х	
Outpatient ervices	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		
leed	Medical transportation (including emergency and non-emergency)	35%	х	35%	х	
mmediate						
	Urgent care	\$55		\$55		
lospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	х	35%	х	
iospital stay	Physician/surgeon fee	35%	х	35%		
Mental	Mental/behavioral health and substance use disorder outpatient office					
nealth, behavioral	visits	\$55		\$55		
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient	\$55		\$55		
buse needs	items and services					
regnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	35%		\$45		
lelp	Outpatient Rehabilitation and Habilitation services	\$55		\$55		
ecovering or ther special	Skilled nursing care	35%	х	35%	х	
ealth needs	Durable medical equipment	35%		35%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic Ind	Sealants per Tooth	Not Covered		Not Covered		
reventive						
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered		
Services	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics					
	Oral Surgery					

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	
tuarial Value - A	V Calculator	71.7%	
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$2,850 integ	
	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	\$2,850 See endr	
Common Medical Event	Service Type	Member Cost Share	Deductible App
LVont	Primary care visit to treat an injury, illness, or condition	25%	х
Health care provider's	Other practitioner office visit	25%	х
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
		25% up to \$250 per	
	Tier 1	script	X
Drugs to	Tier 2	25% up to \$250 per script	х
treat illness or condition	Tier 3	25% up to \$250 per script	х
	Tier 4	25% up to \$250 per script	x
	Surgery facility fee (e.g., ASC)	25%	х
Outpatient services	Physician/surgeon fees	25%	х
	Outpatient visit	25%	х
	Emergency room facility fee (waived if admitted)	25%	х
	Emergency room physician fee (waived if admitted)	0%	х
Need	Medical transportation (including emergency and non-emergency)	25%	x
immediate attention			
	Urgent care	25%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	х
Hospital stay	Physician/surgeon fee	25%	x
Mental	Mental/behavioral health and substance use disorder outpatient office	059/	X
health, behavioral health, or	visits	25%	X
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	х
Help	Outpatient Rehabilitation and Habilitation services	25%	x
recovering or other special	Skilled nursing care	25%	x
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	0	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic 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		
	Endodontics		
Child Dental Major	Periodontics	Not Covered	
Major Services			
	Prosthodontics		
	Oral Surgery		

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan	1
		100%-150%	OFFL	150%-200% FPI	-
tuarial Value - A	V Calculator	94.9%	5	87.9%	
	Plan design includes a deductible?	Yes, Medical/F	harmacy	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A	/ ፻ጋ	N/A \$800 / \$50 / \$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0 \$150 / \$0		\$1,600 / \$100 / \$	
	Individual Out-of-pocket maximum			\$3,150	.0
	Family Out-of-pocket maximum			\$6,300	
	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	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
lealth care provider's office or	Other practitioner office visit	\$5		\$15	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1				
		\$3		\$6	
Drugs to	Tier 2	\$10		\$25	Pharma deductit
reat illness or condition	Tier 3	\$15		\$45	Pharma
					deductit
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharma deductit
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient services	Physician/surgeon fees	10%		20%	
ervices	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
mmediate		\$00		ţ, ţ, ţ	
attention	Urgent care	\$5		\$15	
		ψυ		ψισ	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	Х	20%	x
lospital stay	delivery, mental health, and substance use)		X		
de mén l	Physician/surgeon fee	10%		20%	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ehavioral 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%	х	20%	x
ealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
child over	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	. to onarge		i to charge	
	Preventive - Cleaning				
Child Dental					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
Jei vices	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

-	nefits and Coverage	Silver Plan	
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	-
ctuarial Value - A	V Calculator	74.0%	
	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 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$300 / \$	60
	Individual Out–of–pocket maximum	\$7,550	
	Family Out-of-pocket maximum	\$15,100	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductibl
Event	Primary care visit to treat an injury, illness, or condition	\$50	Applies
Health care	Other practitioner office visit	\$50	
provider's office or		\$30	
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	
	Tier 2	*	Pharma
Drugs to treat illness	Tier 2	\$55	deductib
or condition	Tier 3	\$85	Pharma deductib
	Tier 4	20% up to \$250 per script	Pharma
		after pharmacy deductible	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	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$50	
	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 health,	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
behavioral health, or	VISILS		
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)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or	Skilled nursing care	30%	х
other special health needs	Durable medical equipment	20%	
		No charge	
	Eye exam	_	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	No charge	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

Summary of Benefits and Coverage

Aember Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze HDHP Plan	
Actuarial Value - AV Calculator		64.4%		64.9%	
Plan design includes a deductible?				Yes, integrated	
Plan design includes a deductible		N/A		\$7,050 integrated	
Integrated Family deductible		N/A		\$14,100 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	50	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000 / \$0		N/A	
	Individual Out–of–pocket maximum			\$7,050	
	Family Out-of-pocket maximum	\$18,200		\$14,100	
	HSA plan: Self-only coverage deductible	N/A		\$7,050	
	HSA family plan: Individual deductible	N/A		\$7,050	
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	\$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%	х
	Imaging (CT/PET scans, MRIs)	40%	x	0%	х
	Tier 1	\$17	Pharmacy Deductible	0%	х
				- /3	
Drugs to	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
treat illness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	x
		pharmacy deductible	Deductible		
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
	Surgery facility fee (e.g., ASC)	40%	x	0%	Х
Outpatient	Physician/surgeon fees	40%	x	0%	X
services	Outpatient visit				
		40%	X	0%	X
	Emergency room facility fee (waived if admitted)	40%	X	0%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need immediate attention	Medical transportation (including emergency and non-emergency)	40%	X	0%	Х
	Urgent care	\$60	After 1st three non- preventive visits	0%	х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	x	0%	х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	40%	x	0%	х
Mental		40 %	^	0 78	^
health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	х
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	х
recovering or	Skilled nursing care	40%	x	0%	х
other special health needs	Durable medical equipment	40%	X	0%	x
			^		
	Hospice service	No charge		0%	Х
Child eye care	Eye exam	No charge		No charge	
Juio	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
01/11/2	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Coursed		Not Coursed	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
. revenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic	Periodontal Maintenance Services	Not Covered		Not Covered	
Services					
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
50,71003	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

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

Endnotes to Covered California 2024 Patient-Centered Benefit Plan Designs

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

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2024 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) Where indicated, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, and/or outpatient Mental Health/Substance Use Disorder visits.
- Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

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

by other practitioners for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

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

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

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 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.