Covered California 2023 Patient-Centered Benefit Plan Designs¹

Final Board-approved June 16, 2022

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



Summary of Benefits and Coverage		TM				
- -	_	Individual-only F	Platinum	Individual-only F	Platinum	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	n	
Actuarial Value - A	V Calculator	91.8%		89.8%		
	Plan design includes a deductible?	No		No		
	Integrated Individual deductible	\$0		\$0		
	Integrated Family deductible	\$0		\$0		
			•		^	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$	0	
	Individual Out-of-pocket maximum	\$4,500		\$4,500		
	Family Out-of-pocket maximum	\$9,000		\$9,000		
	HSA plan: Self-only coverage deductible	N/A		N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common	2 71			·		
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Event		Silare	Арріюз	Silare	Арріїсз	
	Primary care visit to treat an injury, illness, or condition	\$15		\$15		
Health care						
provider's	Other practitioner office visit	\$15		\$15		
office or clinic visit	Specialist visit	\$30		\$30		
Omno viole		ΨΟΟ		ΨΟΟ		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$15		\$15		
Tests	X-rays and Diagnostic Imaging	\$30		\$30		
		10%				
	Imaging (CT/PET scans, MRIs)	10%		\$75		
	Tier 1	\$5		\$5		
Drugs to	Tier 2	\$15		\$15		
treat illness	Tier 3	\$25		\$25		
or condition	Her 3	\$25		\$25		
	Tier 4	10% up to \$250 per		10% up to \$250 per		
	1101 4	script		script		
	Surgery facility fee (e.g., ASC)	10%		\$100		
Outpatient	Physician/surgeon fees	10%		\$25		
services	r nysiolan/surgeon rees	1076		φ25		
	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$150		\$150		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Mand		_		_		
Need immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150		
attention						
	Urgent care	\$15		\$15		
		, -		, -		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days		
Hospital stay		400/		_		
	Physician/surgeon fee	10%		No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15		
health, behavioral	visits	φισ		φισ		
health, or	Mantal/habayiaral health and substance use disorder other outpatient					
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15		
abuse needs						
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	10%		\$20		
	Outpatient Rehabilitation and Habilitation services	\$15		\$15		
Help recovering or	Superiorit i toriabilitatiori ariu i iabilitatiori Services	φιο				
other special	Skilled nursing care	10%		\$150 per day up to 5 days		
health needs	Durable medical equipment	10%		10%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Child Daniel	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
and	Sealants per Tooth	No charge		No charge		
Preventive						
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures			See 2022 De-t-1		
Basic		20%		See 2023 Dental Copay Schedule		
Services	Periodontal Maintenance Services			, , , , , , , , , , , , , , , , , , , ,		
	Crowns and Casts					
	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		See 2023 Dental		
Services	Periodontics (other than maintenance)	3076		Copay Schedule		
	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	50%		\$1,000		
Orthodontics	modically ficocooding Officooniuco	30%		φ1,000		

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	Ĭ
ctuarial Value - A		90.7%		88.8%	
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to	Tier 2	\$25		\$20	
treat illness or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
3CI VICCS	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	
mmediate 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)	10%		\$250 per day up to 5 days	
/lental	Physician/surgeon fee	10%		No charge	
nealth, behavioral nealth, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
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 other special	Skilled nursing care	10%		\$150 per day up to 5 days	
health needs	Durable medical equipment	10%		5 days	
	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			3-	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		See 2023 Dental Copay Schedule	
Oci vices	Crowns and Casts				
Child Dental	Endodontics Derivatives (other than maintenance)	F00/		See 2023 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics Oral Surgery				
Child	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
	Wa				
ctuarial Value - A	V Calculator Plan design includes a deductible?	81.9% No		80.1% 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	\$8,550		\$8,550	
	Family Out-of-pocket maximum	\$17,100		\$17,100	
	HSA plan: Self-only coverage deductible	N/A N/A		N/A N/A	
Common	HSA family plan: Individual deductible	N/A		IN/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
Uaalth aava	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's office or	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$60		\$60	
treat illness or condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$150	
Outpatient services	Physician/surgeon fees	20%		\$40	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250	
immediate attention					
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	200/		\$350 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%		5 days No charge	
Mental		5576		. To onargo	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
behavioral health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
recovering or other special	Skilled nursing care	30%		\$150 per day up to	
health needs	Durable medical equipment	20%		5 days 20%	
	Hospice service	No charge		No charge	
01.11.1	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 Charge		No charge	
	Preventive - Cleaning				
Child Dental					
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		See 2023 Dental Copay Schedule	
Services	Periodontal Maintenance Services			,,	
	Crowns and Casts				
Child Dental	Endodontics			See 2023 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB-only Gold Coinsurance Plan		CCSB-only Gold Copay Plan	
Actuarial Value - A	V Calculator	78.9%		80.5%	
	Plan design includes a deductible?	Yes, Medical/Pharma	acy	Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$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 HSA family plan: Individual deductible	N/A N/A		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		\$35	
clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х
	Tier 1	\$15		\$15	
Drugs to treat illness	Tier 2	\$50		\$40	
or condition	Tier 3	\$80		\$70	
	Tier 4	200/ up to \$250 per periot		200/ up to \$250 per perint	
	Hel 4	20% up to \$250 per script		20% up to \$250 per script	
0.4	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х
attention					
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	x	\$600 per day up to 5 days	Х
Hospital stay	Physician/surgeon fee	20%	x	No charge	
Mental	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				
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	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
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				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			Son 2022 Dontal C	
Basic Services	Periodontal Maintenance Services	20%		See 2023 Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2023 Dental Copay	
Services	Prosthodontics	5576		Schedule	
	Oral Surgery				
Child	• •	F02/		M 4.000	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Summary of	f Benefits	and Cove	erage

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Plan
ctuarial Value - A'		71.6%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 / \$85 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$9,500 / \$170 / \$0	
	Individual Out-of-pocket maximum	\$8,750	
	Family Out-of-pocket maximum	\$17,500	
	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
	Primary care visit to treat an injury, illness, or condition	\$45	
Health care provider's office or	Other practitioner office visit	\$45	
clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmac deductible
Drugs to treat illness or condition	Tier 2	\$60	Pharmac deductible
	Tier 3	\$90	Pharmac deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductible
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention	Urgent care	\$45	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	30% 30%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$45	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$ 45	
abuse needs			
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$45	
recovering or 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	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	20%	
Services	Periodontal Maintenance Services Crowns and Casts		
	Endodontics		
Child Dental		5007	
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
Child	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

2023 Patient-Centered Benefit Plan Designs 10.0 FHB Date: June 16, 2022 CCSB-only Summary of Benefits and Coverage **CCSB-only** Silver Silver Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 71.9% Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy Integrated Individual deductible 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% \$300 \$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% Χ Outpatient services Physician/surgeon fees 35% 30% 35% Emergency room facility fee (waived if admitted) 35% Х 30% Χ Emergency room physician fee (waived if admitted) No charge No charge Need Medical transportation (including emergency and non-emergency) 35% 30% Х attention Urgent care \$55 \$55 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 35% 40% Hospital stay 40% Mental Mental/behavioral health and substance use disorder outpatient office \$55 \$55 health, behavioral health, or Mental/behavioral health and substance use disorder other outpatient substance \$55 items and services 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 40% Х other special health needs Durable medical equipment 35% 40% Hospice service No charge No charge 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 2023 Dental Copay Basic Services 20% Schedule Periodontal Maintenance Services Crowns and Casts Child Dental See 2023 Dental Copay Periodontics (other than maintenance) Major 50% Schedule Services Prosthodontics

50%

\$1,000

Oral Surgery

Medically necessary orthodontics

Date: June 16		0000	
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o	
Wellber Goot Chare	anicante describe the Emolice's out of pooled coole.	HDHP PI	an
Actuarial Value - A	V Calculator	71.7%	
	Plan design includes a deductible?	Yes, integr	ated
	Integrated Individual deductible	\$2,700 integ	grated
	Integrated Family deductible	\$5,400 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	N/A \$7,200	
	Family Out-of-pocket maximum		
	HSA plan: Self-only coverage deductible		
	HSA family plan: Individual deductible	See endn	ote
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	25%	Х
Health care provider's office or	Other practitioner office visit	25%	x
clinic visit	Specialist visit	25%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	Х
	Imaging (CT/PET scans, MRIs)	25%	Х
	Tier 1	25% up to \$250 per script	x
Drugs to	Tier 2	25% up to \$250 per	X
treat illness or condition	Tier 3	script 25% up to \$250 per	x
	Tier 4	script 25% up to \$250 per	x
	Surgery facility fee (e.g., ASC)	script 25%	X
Outpatient	Physician/surgeon fees	25%	X
services	Outpatient visit	25%	X
	Emergency room facility fee (waived if admitted)	25%	X
	Emergency room physician fee (waived if admitted)	0%	x
Need	Medical transportation (including emergency and non-emergency)	25%	X
immediate 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%	X
	Physician/surgeon fee	25%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office	25%	x
behavioral health, or	visits		
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	
regnancy	Home health care (cost share per visit)	25%	X
11.1.	Outpatient Rehabilitation and Habilitation services	25%	x
Help recovering or	Skilled nursing care	25%	X
other special health needs	Durable medical equipment	25%	X
	Hospice service	0%	X
Child are	Eye exam	No charge	Λ
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	3.	
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	No charge	
i ieventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	20/0	
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
Child	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	-
uarial Value - A		94.9%		87.9%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/F	harmacy	Yes, Medical/Pharm	acy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$800 / \$25 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0 / \$0		\$1,600 / \$50 / \$0)
	Individual Out-of-pocket maximum	\$900		\$3,000	
	Family Out-of-pocket maximum	\$1,80)	\$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	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	On a station of the	00		405	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
_	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	Pharmacy deductible
David - 4	Tier 2	\$10		\$25	Pharmac
Drugs to reat illness		Ψ10		Ψ20	deductible Pharmac
or condition	Tier 3	\$15		\$45	deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	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 attention					
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	Х	25%	х
lospital stay	Physician/surgeon fee	10%		25%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral	visits	Ψ		\$10	
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	
. ognarioy	Home health care (cost share per visit)	\$3		\$15	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5	_	\$15	
other special	Skilled nursing care	10%	Х	25%	X
nearm needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	NI= =1 · · ·		NI= =L · · · ·	
and Preventive	Sealants per Tooth	No charge		No charge	
. revenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
2	Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	50%		50%	
Major Services	,	JU%		90%	
	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		50%	

Summary of Benefits and Cove

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan	
	·	200%-250% FPL	
Actuarial Value - A	V Calculator	73.9%	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 / \$30 / \$0 \$9,500 / \$60 / \$0	
	Individual Out-of-pocket maximum	\$9,300 / \$00 / \$0	
	Family Out-of-pocket maximum	\$14,500	
	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
	Primary care visit to treat an injury, illness, or condition	\$45	
Health care provider's	Other practitioner office visit	\$45	
office or			
clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$90	
	Imaging (CT/PET scans, MRIs)	\$325	Dharra
	Tier 1	\$16	Pharmacy deductible
Drugs to	Tier 2	\$55	Pharmacy deductible
treat illness or condition	Tier 3	\$85	Pharmacy
or condition	Hel 3	\$00	deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	20%	
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$45	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	Х
Hospital stay	delivery, mental health, and substance use)		~
Mental	Physician/surgeon fee	30%	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$45	
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Uola	Outpatient Rehabilitation and Habilitation services	\$45	
Help recovering or	Skilled nursing care	30%	x
other special health needs			^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge	
	Preventive - Cleaning		
Child Dental	Preventive - Clearing Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
Jei vices	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics	JU 70	
	Prostriodontics Oral Surgery		
Child		5007	
Orthodontics	Medically necessary orthodontics	50%	

Summary (of Benefit	ts and Co	verage

lember Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan	Bronze HDHP Plan		
Actuarial Value - A	V Calculator	64.7%		64.2%	
Actuariai value - A					
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integrat	
	Integrated Individual deductible	N/A N/A		\$7,000 integra	
	Integrated Family deductible	\$6,300 / \$500 / \$0		\$14,000 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental			N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000	ν Φ0	N/A	
	Individual Out-of-pocket maximum	\$8,200		\$7,000	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$16,400 N/A		\$14,000 \$7,000	
	HSA family plan: Individual deductible	N/A N/A		\$7,000	
Common					Deductible
Medical Event	Service Type	Member Cost Share	Deductible Applies After 1st three non-	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$65	preventive visits	0%	Х
provider's	Other practitioner office visit	\$65	After 1st three non- preventive visits	0%	Х
office or clinic visit	Specialist visit	\$95	After 1st three non-	0%	X
	Preventive care/ screening/ immunization		preventive visits		
	·	No charge		No charge	V
	Laboratory Tests	\$40		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	Х
	Imaging (CT/PET scans, MRIs)	40%	X	0%	Х
	Tier 1	\$18	Pharmacy Deductible	0%	Х
_	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X
Drugs to treat illness		pharmacy deductible	Deductible	U%	^
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	00/	v
	Hel 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%	Х
	Emergency room facility fee (waived if admitted)	40%	×	0%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need	Medical transportation (including emergency and non-emergency)	40%	×	0%	Х
immediate	,,	4070	^	0,0	^
attention	Urgent care	\$65	After 1st three non- preventive visits	0%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	40%	X	0%	Х
	Physician/surgeon fee	40%	X	0%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	Х
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	X	0%	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	×	0%	×
Help	Outpatient Rehabilitation and Habilitation services	\$65		0%	x
recovering or	Skilled nursing care			0%	X
other special health needs	-	40%	X		
	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	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
Child Day (a)	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child	,	F00/		F001	
Orthodontics	Medically necessary orthodontics	50%		50%	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan	
tuarial Value - A\	/ Calculator			
	Plan design includes a deductible?	Yes,	integrated	
	Integrated Individual deductible	\$9,100 integrated		
	Integrated Family deductible	\$18,200 integrated N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental			
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
	Individual Out–of–pocket maximum	:	\$9,100	
	Family Out-of-pocket maximum	\$	318,200	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A	
Common Medical	Service Type	Member Cost	Deductible Appl	
Event	Primary care visit to treat an injury, illness, or condition	Share	After 1st three r	
Health care	Filmary care visit to treat an injury, illness, or condition	0%	preventive vis	
provider's	Other practitioner office visit	0%	preventive vis	
office or clinic visit	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	0%	X	
Tests	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	x	
		0%		
	Tier 1	0%	X	
Drugs to	Tier 2	0%	X	
treat illness				
or condition	Tier 3	0%	X	
	Tier 4	0%	x	
	Surgery facility fee (e.g., ASC)	0%	X	
Outpatient	Physician/surgeon fees	0%	X	
services	Outpatient visit	0%	X	
	Emergency room facility fee (waived if admitted)	0%	X	
No. 1	Emergency room physician fee (waived if admitted)	No charge		
Need immediate attention	Medical transportation (including emergency and non-emergency)	0%	X	
	Urgent care	0%	After 1st three r	
	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	0%	After 1st three r	
health, behavioral health, or	visits	0 78	preventive vis	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	0%	Х	
Help	Outpatient Rehabilitation and Habilitation services	0%	x	
recovering or	Skilled nursing care	0%	x	
other special health needs	Durable medical equipment	0%	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)	0%	X	
	Oral Exam			
Child Dontol	Preventive - Cleaning			
Child Dental Diagnostic	Preventive - X-ray	No charge		
and Preventive	Sealants per Tooth	No charge		
11010111110	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Services	0%	Х	
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	0%	X	
	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	0%	×	

Medically necessary orthodontics

0%

X

2023 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: June 16, 2022

Summary of Benefits and Coverage



Summary of Ber	nefits and Coverage	ТІ	M		
-		Individual-only F	Platinum	Individual-only F	Platinum
Member Cost Snare	amounts describe the Enrollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	ın
Actuarial Value - A	V Calculator	91.8%		89.8%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common	• •				
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event		Silare	Арріїез	Silare	Арріїсз
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care					
provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
Omno viole	•	ΨΟΟ		ΨΟΟ	
	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	
	imaging (OT/I ET Soans, IVIINS)	1076		φ/5	
	Tier 1	\$5		\$5	
	Tue	_		_	
Drugs to	Tier 2	\$15		\$15	
treat illness or condition	Tier 3	\$25		\$25	
or condition	1101 0	ΨΣΟ		ΨΣΟ	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
		script		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)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate	modela unicportation (modeling emolgency und non emolgency)	Ψ130		Ψ130	
attention					
	Urgent care	\$15		\$15	
	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	
copital olay	Physician/surgeon fee	10%		No charge	
Mental					
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
behavioral					
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services	ΨΙΟ		ΨΙΟ	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
23.11.13		_		_	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
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	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
		ivo cilaige		ivo cilaige	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	·				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Periodontics (other than maintenance)	1401 Covered		TAOL COVERED	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics		1101 OUVEIEU		1101 OUVEIGU	

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	i
tuarial Value - A		90.7%		88.8%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0 \$0		\$0 \$0	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$		\$0/\$0/\$	
	Individual Out-of-pocket maximum	\$4,500	-	\$4,500	•
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	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	\$10		\$5	
Drugs to treat illness	Tier 2	\$25		\$20	
or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
Atomion	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 nealth, pehavioral	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	
Uoln	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
Help recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs				5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services			2. 23.0.00	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child					

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
uarial Value - A	V/ Coloulator	81.9%		80.1%	
uariai value - A	Plan design includes a deductible?	01.9% No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Framily deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$	60
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0/\$0/\$	60
	Individual Out-of-pocket maximum	\$8,550		\$8,550	
	Family Out-of-pocket maximum	\$17,100		\$17,100	
	HSA plan: Self-only coverage deductible	N/A		N/A	
•	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's office or clinic visit	Other practitioner office visit	\$35		\$35	
	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$60		\$60	
reat illness or condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$150	
Outpatient services	Physician/surgeon fees	20%		\$40	
301 11000	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			\$350 per day up to	
Hospital stay	delivery, mental health, and substance use)	30%		5 days	
Mental	Physician/surgeon fee	30%		No charge	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
health, 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	
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	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 and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
01.11.5	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	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2023 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: June 16, 2022

Date: June 16					
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		CCSB-only Gold	
		Coinsurance Pla	n	Copay Plan	
Actuarial Value - A	V Calculator	78.9%		80.5%	
	Plan design includes a deductible?		acy	Yes, Medical/Phari	macy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible			N/A	
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	\$25		\$35	
Health care provider's	Other practitioner office visit	\$25		\$35	
office or clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
	Tier 1	\$15		\$15	
		·			
Drugs to treat illness	Tier 2	\$50		\$40	
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	X
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	20%	X	\$250	X
attention	Urgent care	\$25		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X X	\$600 per day up to 5 days	Х
Mental	Physician/surgeon fee	20%	^	No charge	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
abuse needs	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Home health care (cost share per visit)	No charge		No charge \$30	
Hale	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
Help recovering or					V
other special health needs	Skilled nursing care	20%	X	\$300 per day up to 5 days	X
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
A. I	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
O modomics					

ember Cost Snare	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
tuarial Value - A	V Calculator	71.6%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	aoy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 / \$85 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$9,500 / \$170 / \$	0
	Individual Out-of-pocket maximum	\$8,750	
	Family Out-of-pocket maximum	\$17,500	
	HSA plan: Self-only coverage deductible	N/A	
Common	HSA family plan: Individual deductible	N/A	I
Common Medical Event	Service Type	Member Cost Share	Deductil Applie
	Primary care visit to treat an injury, illness, or condition	\$45	
Health care provider's	Other practitioner office visit	\$45	
office or clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
			Pharma
	Tier 1	\$16	deducti
Drugs to	Tier 2	\$60	Pharma deducti
treat illness or condition	Tier 3	\$90	Pharma deducti
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deducti
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention	Urgent care	\$45	
	organicane	ΨΨΟ	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х
Hospital stay	Physician/surgeon fee	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$45	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$45	
recovering or	Skilled nursing care	30%	x
other special health needs			
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	5570100	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental		Not Covered	
Major Services	Periodontics (other than maintenance)	NOI Covered	
	Prosthodontics Oral Surgery		
a	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

2023 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: June 16, 2022

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		
Actuarial Value - A	V Calculator	71.9%		71.7%		
Actuariai value - A	Plan design includes a deductible?	Yes, Medical/Pharma	acv.	Yes, Medical/Pharm	201	
	Integrated Individual deductible	N/A	icy	N/A	acy	
	Integrated Framily deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0		\$2,500 / \$300 / \$6	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	\$17,200		\$17,500		
	HSA plan: Self-only coverage deductible	N/A		N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	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						
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	Х	
	Tier 1	\$20		\$19		
	Tier 2	\$75	Pharmacy	\$85	Pharmacy	
Drugs to treat illness	Hel Z	\$75	deductible	684	deductible	
or condition	Tier 3	\$105	Pharmacy deductible	\$110	Pharmacy 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%	X	35%	Х	
Outpatient services	Physician/surgeon fees	35%		30%		
	Outpatient visit	35%		30%		
	Emergency room facility fee (waived if admitted)	35%	Х	30%	Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	35%	X	30%	X	
immediate attention						
	Urgent care	\$55		\$55		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
Hospital stay	delivery, mental health, and substance use)	35%	X	40%	Х	
, ,	Physician/surgeon fee	35%	X	40%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55		
behavioral health, or	Montel/habovieral health and substance use disorder other outrations					
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 other special	Skilled nursing care	35%	X	40%	х	
health needs	Durable medical equipment	35%		40%		
	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			, and the second		
	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					
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		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		

Date: June 1		000D -	m.h.
-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver	•
Weinber Goot Ghare	a amounts describe the Enforce seat of people tests.	HDHP P	lan
Actuarial Value - A	AV Calculator	71.7%)
	Plan design includes a deductible?	Yes, integ	rated
	Integrated Individual deductible	\$2,700 integ	grated
	Integrated Family deductible	\$5,400 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A N/A	
	Individual Out-of-pocket maximum	\$7,200)
	Family Out-of-pocket maximum		
	HSA plan: Self-only coverage deductible	\$2,700)
	HSA family plan: Individual deductible	See endr	note
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	
	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 illness	Tier 2	script	X
or condition	Tier 3	25% up to \$250 per script	X
	Tier 4	25% up to \$250 per script	X
	Surgery facility fee (e.g., ASC)	25%	X
Outpatient	Physician/surgeon fees	25%	X
services	Outpatient visit	25%	X
	Emergency room facility fee (waived if admitted)	25%	Х
	Emergency room physician fee (waived if admitted)	0%	X
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%	X
Hospital stay	Physician/surgeon fee	25%	X
Mental	Mental/behavioral health and substance use disorder outpatient office	050/	
health, behavioral	visits	25%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient	25%	X
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	25%	X
other special health needs	Skilled nursing care	25%	X
nealth needs	Durable medical equipment	25%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
Julio	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		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	
Orthodontics			

2023 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: June 16, 2022

Summary of Be	nefits and Coverage				
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPI	
Actuarial Value - A	V Calculator	94.9%	6	87.9%	
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	·	N/A	,
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/\$0	\$800 / \$25 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0	/\$0	\$1,600 / \$50 / \$0)
	Individual Out-of-pocket maximum	\$900		\$3,000	
	Family Out-of-pocket maximum	\$1,80	0	\$6,000	
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible			N/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	\$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	
T	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	Pharmacy deductible
Drugs to	Tier 2	\$10		\$25	Pharmacy deductible
treat illness or condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4	10% up to \$150 per		15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		15%	doddollaio
Outpatient	Physician/surgeon fees	10%		15%	
services	Outpatient visit	10%		15%	
	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	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	10% 10%	X	25% 25%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
behavioral 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%	X	25%	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	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
01.11.15	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics	Wiculdally Hecessary Uttillouofillios	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	
		200 /0-230 /0 FPI	
tuarial Value - A	V Calculator	73.9%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 / \$30 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$9,500 / \$60 / \$0)
	Individual Out-of-pocket maximum	\$7,250	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$14,500 N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductil Applie
	Primary care visit to treat an injury, illness, or condition	\$45	
Health care provider's	Other practitioner office visit	\$45	
office or clinic visit	Specialist visit	\$85	
omino vion	'		
	Preventive care/ screening/ immunization	No charge	
Toots	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$90	
	Imaging (CT/PET scans, MRIs)	\$325	6:
	Tier 1	\$16	Pharma deducti
Drugs to	Tier 2	\$55	Pharma
treat illness or condition	Tier 3	\$85	Pharma
	Tier 4	20% up to \$250 per script	deductil Pharma
		after pharmacy deductible	deducti
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention	Urgent care	\$45	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	2007	V
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30% 30%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$45	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$45	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$45	
recovering or	Skilled nursing care	30%	X
other special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam 1 pair of glosses per year (or contact lesses in liquid glosses)	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
01.11.5	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child			

2023 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: June 16, 2022

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze	
				HDHP Pla	n
ctuarial Value - A'	V Calculator	64.7%		64.2%	
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integra	ted
	Integrated Individual deductible	N/A		\$7,000 integra	ated
	Integrated Family deductible	N/A		\$14,000 integr	rated
	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	\$8,200		\$7,000	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$16,400 N/A		\$14,000 \$7,000	
	HSA family plan: Individual deductible	N/A		\$7,000	
Common	0 t -				Deductible
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	X
Health care provider's	Other practitioner office visit	\$65	After 1st three non-	0%	×
office or	·		preventive visits After 1st three non-		
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	Х
	Tier 1	\$18	Pharmacy Deductible	0%	x
_	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X
Drugs to treat illness	1101 2	pharmacy deductible	Deductible	0 78	^
or condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 4	40% up to \$500 per script after	Pharmacy	0%	×
		pharmacy deductible	Deductible	0,0	^
Outpatient	Surgery facility fee (e.g., ASC)	40%	X	0%	Х
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%	Х
Need	Medical transportation (including emergency and non-emergency)	40%	x	0%	X
immediate attention					
	Urgent care	\$65	After 1st three non- preventive visits	0%	X
			proventive views		
	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%	×
Mental		40 /0		070	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	Х
behavioral health, or	Mantal/habanianal haalibaanda ubabanan uu dianada abban ada abiint				
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	X	0%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
gy	Home health care (cost share per visit)	40%	X	0%	X
	Outpatient Rehabilitation and Habilitation services	\$65		0%	X
Help recovering or					
other special health needs	Skilled nursing care	40%	X	0%	X
	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				
OFFICE	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
. TO FOILING	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan
tuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$9,100 integrated \$18,200 integrated	
	Integrated Family deductible		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum		N/A \$9,100
	Family Out-of-pocket maximum		618,200
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Appl
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three r
Health care provider's	Other practitioner office visit	0%	After 1st three r
office or clinic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	,
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	x
	Tier 1	0%	x
	Tier 2	0%	
Drugs to reat illness			X
or condition	Tier 3	0%	X
	Tier 4	0%	Х
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	0%	X
attention	Harrison		After 1st three r
	Urgent care	0%	preventive vis
	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	•	0%	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three r
health, or	Mental/behavioral health and substance use disorder other outpatient		
substance abuse needs	items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	x
nealth needs	Durable medical equipment	0%	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)	0%	X
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

Endnotes to Covered California 2023 Patient-Centered Benefit Plan Designs

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

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2023 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the non-HDHP Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2023 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, 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.
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;
	Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
4	Drugs that are biologics and drugs that the Food and
	Drug Administration (FDA) or drug manufacturer requires to
	be distributed through specialty pharmacies;
	2) Drugs that require the enrollee to have special training or
	clinical monitoring;
	3) Drugs that cost the health plan (net of rebates) more than
	six hundred dollars (\$600) net of rebates for a one-month
	supply.

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2023 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.