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).

Date: June 16, 2022

Summary of Benefits and Coverage

COVERED

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Individual-only Platinum Coinsurance Plan		Individual-only Platinum Copay Plan	
Actuarial Value - A		91.8% No		89.8% No	
	Plan design includes a deductible? Integrated Individual deductible	No \$0		\$0	
	Integrated Framily deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common					
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
		ψυ			
Drugs to	Tier 2	\$15		\$15	
treat illness or condition	Tier 3	\$25		\$25	
	Tion A	10% up to \$250 per		10% up to \$250 per	
	Tier 4	script		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)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention					
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
Troophar stay	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
health, behavioral	visits	φ15		φ15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services	Ψισ		Ψισ	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
·	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No oborg-		No obsess	
and Preventive	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2023 Dental	
Services	Periodontal Maintenance Services	2076		Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See 2023 Dental Copay Schedule	
Services	Prosthodontics			',	
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

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

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	Ī	CCSB-onl Platinum Copay Pla	
tuarial Value - A	V Calculator	90.7%		88.8%	
	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 HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common	To that my plant matrical codecise				
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization				
	Laboratory Tests	No charge \$15		No charge \$20	
Tests	X-rays and Diagnostic Imaging				
. 5515		\$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	Physician/surgeon fees	10%		\$25	
services	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	modela transportation (modeling emergency and non-emergency)	\$130		\$130	
attention	Urgent care	\$15		\$20	
	organicalia	φισ		Ψ20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office			-	
health, behavioral	visits	\$15		\$20	
health, or	Mental/behavioral health and substance use disorder other outpatient			_	
substance abuse needs	items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or other special	Skilled nursing care	10%		\$150 per day up to	
health needs	Durable medical equipment	10%		5 days 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	. 10 0.10190		. 15 Shargo	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	,	No charge		No charge	
Preventive	Sealants per Tooth Topical Elugide Application				
	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	F601		See 2023 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics				
OFILE	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Gold Coinsurance Plan		Individual-only Gold Copay Plan	
	W0 + 1 +				
tuarial Value - A		81.9%		80.1% No	
	Plan design includes a deductible?	No \$0		\$0	
	Integrated Individual deductible Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	ın.
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$8,550	,	\$8,550	
	Family Out-of-pocket maximum			\$17,100	
	HSA plan: Self-only coverage deductible	N/A	N/A		
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care	Other practitioner office visit	\$35		\$35	
provider's office or	Other practitioner office visit	ψ33		Ψ55	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Гests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1				
	nor I	\$15		\$15	
Orugs 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	Physician/surgeon fees	20%		\$40	
services	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 mmediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
ttention					
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%		\$350 per day up to 5 days	
Hospital stay	Physician/surgeon fee	30%		No charge	
Mental		5070		140 onlargo	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
behavioral health, or					
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
abuse needs		N		NI= =1	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
recovering or other special	Skilled nursing care	30%		\$150 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
	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	No charge		No charge	
and Preventive	Sealants per Tooth	1.0 0.10190		. 10 Shargo	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2023 Dental	
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental		E00/		See 2023 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

Summary of Benefits and Coverage		CCSB-only		CCSB-only		
-	amounts describe the Enrollee's out of pocket costs.	Gold		Gold		
	·	Coinsurance Pla	n	Copay Plan		
Actuarial Value - A	V Calculator	78.9%	1	80.5%		
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	Yes, Medical/Pharmacy		
	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		N/A		N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common Medical	Consider Time	Member Cost Share	Deductible	Marris on Coast Chann	Deductible	
Event	Service Type	Welliber Cost Share	Applies	Member Cost Share	Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care						
provider's office or	Other practitioner office visit	\$25		\$35		
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х	
					·	
	Tier 1	\$15		\$15		
Drugs to	Tier 2	\$50		\$40		
treat illness	Tion 0	•••		•		
or condition	Tier 3	\$80		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	2 () () () () ()					
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$300	Х	
services	Physician/surgeon fees	20%		\$35		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х	
immediate attention						
	Urgent care	\$25		\$35		
	- · g - · · · · · · · ·	Ψ20		Ψοσ		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
Hospital stay	delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	Х	
, ,	Physician/surgeon fee	20%	X	No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office					
health, behavioral	visits	\$25		\$35		
health, or	Mental/behavioral health and substance use disorder other outpatient					
substance abuse needs	items and services	\$25		\$35		
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	\$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	Ů		Ů		
	Preventive - Cleaning					
Child Dental						
Diagnostic and	Preventive - X-ray	No charge		No charge		
Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		See 2023 Dental Copay		
Services	Periodontal Maintenance Services	2070		Schedule		
	Crowns and Casts					
Ar	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		See 2023 Dental Copay		
Services	Prosthodontics			Schedule		
	Oral Surgery					
Child				<u> </u>		
Orthodontics	Medically necessary orthodontics	50%		\$1,000		

Date: June 16, 2022

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	r Plan
tuarial Value - A	V Calculator	71.6%	
luariai value - A	Plan design includes a deductible?	Yes, Medical/Pharm	201
	Integrated Individual deductible	N/A	асу
	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 / \$6	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	Deductibl Applies
LVCIII	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	
	Tier 1	\$16	Pharmad
			deductib Pharma
Drugs to	Tier 2	\$60	deductib
treat illness or condition	Tier 3	\$90	Pharma deductib
		20% up to \$250 per script	Pharma
	Tier 4	after pharmacy deductible	deductib
	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	modean taneportation (modeling emergency and non-emergency)	Ψ200	
attention	Urgent ears	0.45	
	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)		
Mandal	Physician/surgeon fee	30%	
Mental 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)	\$45	
llala.	Outpatient Rehabilitation and Habilitation services	\$45	
Help recovering or	·		.,
other special health needs	Skilled nursing care	30%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No. 1	
and Preventive	Sealants per Tooth	No charge	
revende	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	20%	
Services			
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		

Medically necessary orthodontics

Prosthodontics Oral Surgery

50%

Date: June 16	5, 2022					
Summary of Ber	nefits and Coverage	CCSB-only		CCSB-only		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plar	1	Silver Copay Plan		
				. ,		
Actuarial Value - A	V Calculator	71.9%		71.7%		
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharmacy		
	Integrated Individual deductible	N/A		N/A		
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0		\$2,500 / \$300 / \$6)	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$6)	
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	Consider Time	Marshan Coat Chara	Deductible	Marshan Cast Chara	Deductible	
Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies	
	Primary care visit to treat an injury, illness, or condition	\$55		\$55		
Health care	Other production of the state	0.5		0.55		
provider's office or	Other practitioner office visit	\$55		\$55		
clinic visit	Specialist visit	\$90		\$90		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$55		\$55		
Tests	X-rays and Diagnostic Imaging	\$90		\$90		
	Imaging (CT/PET scans, MRIs)	35%	X	\$300	X	
		30%	^	φουυ	^	
	Tier 1	\$20		\$19		
Down to	Tier 2	\$75	Pharmacy	\$85	Pharmacy	
Drugs to treat illness		***	deductible	***	deductible	
or condition	Tier 3	\$105	Pharmacy deductible	\$110	Pharmacy deductible	
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharmacy	
	1101 4	pharmacy deductible	deductible	pharmacy deductible	deductible	
	Surgery facility fee (e.g., ASC)	35%	Х	35%	Х	
Outpatient services	Physician/surgeon fees	35%		30%		
services	Outpatient visit	35%		30%		
	Emergency room facility fee (waived if admitted)	35%	Х	30%	×	
			Α		^	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate	Medical transportation (including emergency and non-emergency)	35%	Х	30%	X	
attention						
	Urgent care	\$55		\$55		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	35%	X	40%	Х	
Hospital stay	delivery, mental health, and substance use)				,	
	Physician/surgeon fee	35%	X	40%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$55		\$55		
behavioral	visits	,,,,		***		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$55		\$55		
abuse needs	items and services	φοσ		ΨΟΟ		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	35%		\$45		
Uela	Outpatient Rehabilitation and Habilitation services	\$55		\$55		
Help recovering or		·	.,			
other special health needs	Skilled nursing care	35%	X	40%	X	
nounn necus	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					
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic and		No charge		No charge		
Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		See 2023 Dental Copay		
Services	Periodontal Maintenance Services	2070		Schedule		
	Crowns and Casts					
	Endodontics					
Child Dental		E00/		See 2023 Dental Copay		
Major Services	Periodontics (other than maintenance)	50%		Schedule		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		
Cloudililio						

-	Senefits and Coverage are amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	•
ctuarial Value -	AV Calculator	71.7%)
	Plan design includes a deductible?	Yes, integr	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	
	Family deductible, NOT integrated: wiedical / Pharmacy / Dental Individual Out–of–pocket maximum	\$7,200)
	Family Out-of-pocket maximum	\$14,40	
	HSA plan: Self-only coverage deductible	\$2,700)
O	HSA family plan: Individual deductible	See endr	ote
Common Medical Event	Service Type	Member Cost Share	Deductible App
	Primary care visit to treat an injury, illness, or condition	25%	х
Health care provider's	Other practitioner office visit	25%	x
office or clinic visit	Specialist visit	25%	x
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	×
	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	×
	Tier 4	25% up to \$250 per script	x
Outpatient services	Surgery facility fee (e.g., ASC)	25%	X
	Physician/surgeon fees	25%	x
	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%	×
immediate attention			
	Urgent care	25%	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	25%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	25%	X
Mental	Mental/behavioral health and substance use disorder outpatient office	250/	X
health, behavioral	visits	25%	^
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	25%	x
abuse needs Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	х
Help	Outpatient Rehabilitation and Habilitation services	25%	×
recovering o		25%	×
other specia health needs	1	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		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	NI= =1 · · · ·	
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	_0,0	
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
20111003	Prosthodontics		
01.71	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
uorial V	W Calculator			07 227	
uarial Value - A	V Calculator Plan design includes a deductible?	94.9% Yes, Medical/F		87.9% Yes, Medical/Pharm	acv
	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	\$1,800)	\$6,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common		Member Cost	Deductible		Deductil
Medical Event	Service Type	Share	Applies	Member Cost Share	Applies
lealth care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
rovider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
ests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1				Pharma
	nei i	\$3		\$5	deducti
rugs to	Tier 2	\$10		\$25	Pharma deductil
eat illness r condition	Tier 3	\$15		\$45	Pharma
		10% up to \$150 per			deducti Pharma
	Tier 4	script		15% up to \$150 per script	deducti
	Surgery facility fee (e.g., ASC)	10%		15%	
outpatient ervices	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	
leed	Medical transportation (including emergency and non-emergency)	\$30		\$75	
mmediate					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	Х	25%	Х
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		25%	
lental		.570		2370	
ealth, ehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ealth, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$5		\$15	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
loln	Outpatient Rehabilitation and Habilitation services	\$5 \$5		\$15	
lelp ecovering or	Skilled nursing care	10%	Х	25%	Х
ther special ealth needs			٨		^
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye are	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
hild Dental	Preventive - Cleaning				
iagnostic	Preventive - X-ray	No charge		No charge	
nd reventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
child Dental	Restorative Procedures	20%		20%	
ervices	Periodontal Maintenance Services	2070		2378	
	Crowns and Casts				
Child Dental	Endodontics				
//////////////////////////////////////	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL		
otu ori-11/	W Coloulator	70.00		
ctuarial Value - A	V Calculator Plan design includes a deductible?	73.9% Yes, Medical/Pharm	201	
	Integrated Individual deductible	N/A	acy	
	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	\$14,500		
	HSA plan: Self-only coverage deductible	N/A		
Common	HSA family plan: Individual deductible	N/A		
Medical Event	Service Type	Member Cost Share	Deductib 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		
	Tier 1	\$16	Pharmad	
	Tier 2	\$55	deductib Pharma	
Drugs to treat illness		фээ	deductib Pharma	
or condition	Tier 3	\$85	deductib	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib	
	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 immediate	Medical transportation (including emergency and non-emergency)	\$250		
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		
. rog.lulloy	Home health care (cost share per visit)	\$40		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$45		
other special health needs	Skilled nursing care	30%	Х	
Julia necus	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
Child Dontal	Preventive - Cleaning			
Child Dental Diagnostic	Preventive - X-ray	No charge		
and Preventive	Sealants per Tooth	140 Glarge		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	20%		
Services	Periodontal Maintenance Services	20%		
	Crowns and Casts			
Child B	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	50%		
Services	Prosthodontics			
	Oral Surgery			

ombo- 0 : 0:	amounts describe the Encelleds and of sectles and			Bronze	
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		HDHP Pla	n
ctuarial Value - A\	V Calculator	64.7%		64.2%	
	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integrat	ted
	Integrated Individual deductible	N/A		\$7,000 integrated	
	Integrated Family deductible	N/A		\$14,000 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	60	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	\$16,400		\$14,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		\$7,000 \$7,000	
Common	TIGA family plan. Individual deductible	IWA		\$7,000	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non- preventive visits	0%	X
Health care provider's	Other practitioner office visit	\$65	After 1st three non- preventive visits	0%	Х
office or clinic visit	Specialist visit	¢oe.	After 1st three non-	00/	
CITIIC VISIT		\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tank	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%	х
Davis 1	Tier 2	40% up to \$500 per script after	Pharmacy	0%	x
Drugs to treat illness or condition	Tier 3	pharmacy deductible 40% up to \$500 per script after pharmacy deductible	Deductible Pharmacy Deductible	0%	x
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
	Surgery facility fee (e.g., ASC)	40%	x	0%	X
Outpatient	Physician/surgeon fees	40%	×	0%	X
services	, ,				
	Outpatient visit	40%	X	0%	X
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need immediate attention	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
	Urgent care	\$65	After 1st three non- preventive visits	0%	X
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	х	0%	X
	Physician/surgeon fee	40%	X	0%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	x	0%	x
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	\$65		0%	X
recovering or	Skilled nursing care	40%	×	0%	X
other special health needs	Durable medical equipment	40%	X	0%	X
			^		
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	. to shargo		, to shargo	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental		F00/		5007	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

Summary	/ of	Benefits	and	Coverage

Summary of Bei	nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catas	rophic Plan
Actuarial Value - A	W Calculator		
Actuariai value - A	Plan design includes a deductible?	Yes.	integrated
	Integrated Individual deductible		0 integrated
	Integrated Family deductible	\$18,20	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		\$9,100
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	1	18,200 N/A
	HSA family plan: Individual deductible		N/A
Common Medical	Service Type	Member Cost	Deductible Applies
Event		Share	After 1st three non-
Health care	Primary care visit to treat an injury, illness, or condition	0%	preventive visits
provider's	Other practitioner office visit	0%	After 1st three non- preventive visits
office or clinic visit	Specialist visit	0%	×
	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%	х
	Tier 2	0%	X
Drugs to treat illness		0 78	^
or condition	Tier 3	0%	X
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient services	Physician/surgeon fees	0%	x
33.1.333	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%	×
attention			
	Urgent care	0%	After 1st three non- preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
behavioral health, or	visito		preventive visits
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%	x
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	×
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No oborgo	
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	X
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics	25:	
Major Services	Periodontics (other than maintenance)	0%	X
	Prosthodontics Oral Surgery		
Child	Oral Surgery Medically peops any orthodoxtics	001	
Orthodontics	Medically necessary orthodontics	0%	Х

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver 94 100%-150%		Silver 87 Plan 150%-200% FPL		
	V Caladata	05.40		00.00/		
uarial Value - A'	V Calculator Plan design includes a deductible?	95.1% Yes, Medical/F		88.6% Yes Medical/Pharm	acv	
	Integrated Individual deductible	N/A	паппасу	Yes, Medical/Pharmacy N/A		
Integrated Family deductible		N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0		
	Individual Out-of-pocket maximum	\$900		\$3,000		
	Family Out-of-pocket maximum)	\$6,000		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A		
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appli	
Event	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
lealth care				·		
orovider's	Other practitioner office visit	\$5		\$15		
clinic visit	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$8		\$20		
ests	X-rays and Diagnostic Imaging	\$8		\$40		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
	Tier 1	\$3		\$5		
	Tier 2	\$10		\$25		
Orugs to reat illness		Ψισ		ΨΣΟ		
or condition	Tier 3	\$15		\$45		
	Tier 4	10% up to \$150 per script		15% up to \$150 per script		
	Surgery facility fee (e.g., ASC)	10%		15%		
Outpatient ervices	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		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100/		05%		
Hospital stay	delivery, mental health, and substance use)	10%		25%		
	Physician/surgeon fee	10%		25%		
Mental nealth, nehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15		
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15		
buse needs	Prenatal care and preconception visits	No chargo		No oborgo		
Pregnancy	Home health care (cost share per visit)	No charge		No charge		
		\$3		\$15		
Help ecovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15		
other special	Skilled nursing care	10%		25%		
nealth 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= =1 · · · ·		
and Preventive	Sealants per Tooth	No charge		No charge		
. CVSHUVE	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures	0001		0007		
Basic Bervices	Periodontal Maintenance Services	20%		20%		
	Crowns and Casts					
	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		50%		
Services	Prosthodontics					
	Oral Surgery					

	amounts describe the Enrollee's out of pocket costs.	Silver 80 Plan 200%-600% FPL	
tuarial Value - A'	V Calculator	81.0%	
tuariar value - A	Plan design includes a deductible?	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	шоу
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$4,900	
	Family Out-of-pocket maximum	\$9,800	
	HSA family plan: ladividual doductible	N/A N/A	
Common	HSA family plan: Individual deductible		Deductib
Medical Event	Service Type	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$30	
Health care provider's	Other practitioner office visit	\$30	
office or clinic visit	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$80	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$10	
Drugs to	Tier 2	\$40	
treat illness or condition	Tier 3	\$70	
c. condition			
	Tier 4	20% up to \$250 per script after pharmacy deductible	
	Surgery facility fee (e.g., ASC)	20%	
Outpatient services	Physician/surgeon fees	20%	
30111000	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		¥	
attontion	Urgent care	\$30	
	3	ψ00	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	
Mental		30 %	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$30	
behavioral health, or	Mandal/habasianal bankhanad ashakana saya dia adaa akkanasada akkanasada ak		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$30	
recovering or other special	Skilled nursing care	30%	
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Obilet	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	140 onlingo	
	Preventive - Cleaning		
Child Dental	Preventive - Clearing Preventive - X-ray		
Diagnostic and		No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dontal	Restorative Procedures	20%	
Basic	Periodontal Maintenance Services		
Basic			
Basic	Crowns and Casts		
Basic Services Child Dental	Endodontics		
Child Dental Basic Services Child Dental Major Services		50%	
Basic Services Child Dental Major	Endodontics	50%	

Date: June 16, 2022

Summary of Benefits and Coverage

COVERED

Prevention of the process of the control of the process of the control of the con	Summary of Bei	nefits and Coverage	TI	M		
Common C	-	_	Individual-only F	Platinum	Individual-only F	latinum
Personal recitable in Personal recitable in Personal Residual Science in Personal distribution in Personal Residual Science in Personal Residual Science in Personal S	Member Cost Share	amounts describe the Enrollee's out or pocket costs.	Coinsurance	Plan	Copay Pla	n
Personal recitable in Personal recitable in Personal Residual Science in Personal distribution in Personal Residual Science in Personal Residual Science in Personal S						
Integrated information and statements in register after high desirable in the content of the production of the productio	Actuarial Value - A	V Calculator	91.8%		89.8%	
Individual aduation (In Trespense). Medical Frameway Certain Framity additionable, NOT integrated. Medical Frameway Certain Framity and Provided Prameway Certain No. 1800.00 1800.00		Plan design includes a deductible?	No		No	
Individual aduation (In Trespense). Medical Frameway Certain Framity additionable, NOT integrated. Medical Frameway Certain Framity and Provided Prameway Certain No. 1800.00 1800.00		Integrated Individual deductible	\$0		\$0	
Production deceated, NCT integrated. Medical / Pharmacy / Deceat						
Family deduction, NOT responsed, Medical Plannarus (1997) 2016 2017 201				0		0
Interiodace Dut of process maintains Framely Code process main						
Secretary Secr		Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
MA NA NA NA NA NA NA NA		Individual Out-of-pocket maximum	\$4,500		\$4,500	
March Marc		Family Out-of-pocket maximum	\$9,000		\$9,000	
March Marc		HSA plan; Self-only coverage deductible	N/A		N/A	
Service Types Service Type		•				
Medical Service Type	Common	· · · · · · · · · · · · · · · · · · ·				
Petinary care visit to treat an injury, titrees, or condition \$15		Service Type				Deductible
New York Section Sec	Event		Silare	Дрріїез	Silare	Арріїсз
Drogs to Chief predictions of the view of clinic vi		Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Child Deptid stay Frequency Freedball And Covered Media deptid stays on the stay of the	Health care					
Preventive care's screening innovation Social Social Social Social Preventive care's screening innovation Social So		Other practitioner office visit	\$15		\$15	
Percentive card secreting immunization Laboratory Tests Laboratory Tests X-rays and Diagnostic Imaging S00 \$300 Imaging (CFPET scare, MRts) Tor 1 Tor 1 S5 \$35 Tor 1 Tor 2 Tor 2 Tor 3 Tor 3 Tor 4 Tor 5 Supery facility for (e.g., ASC) Physicianishurgeon fees Outpatient services Outpatient services Outpatient services Outpatient services Outpatient services Outpatient visit Emergency room facility fee (walved if admitted) Emergency room facility fee (walved if admitted) Emergency room facility fee (walved if admitted) Immediate attention Urgent care Facility fee (e.g., Despital room) for inpetient stay (including labor and delivery, metal health, and substance use) Physicianishurgeon fee Physicianishurgeon fee Physicianishurgeon fee Physicianishurgeon fees Physicianishurgeon fees Tor 3 Super face (e.g., Despital room) for inpetient stay (including labor and delivery, metal health, and substance use) Physicianishurgeon fee Wental health, and substance use disorder outpatient office visits Physicianishurgeon fee Wental health, and substance use disorder outpatient office visits Programmy Physicianishurgeon fee Wental health, and substance use disorder outpatient office visits Programmy Preventile Programmy Preventile Child devial preventile Child devial preventile Child devial preventile Child devial programmy Preventile Child bental face of the financial equipment Preventile Oral Exam Correct College of the financial equipment Preventile Child bental face of the financial equipment Preventile Oral Exam College of the financial equipment Preventile Oral Exam College of the financial equipment Preventile Oral Exam Coll Services Programmy Preventile Child Bental face of the financ		Specialist visit	\$20		\$20	
Texts Varyar and Diagnostic Invaging S15 S15 S15 S30	Omno viole		φου		φου	
Tests X-rays and Diagnostic Imaging \$30 \$30 \$30 \$75		Preventive care/ screening/ immunization	No charge		No charge	
Imaging (CTPPET scens, NRIss) Tier 1 Tier 1 Tier 2 Tier 2 Tier 3 Tier 3 Tier 3 Tier 3 Tier 4 Tier 4 Tier 4 Tier 4 Tier 5 Tier 4 Tier 4 Tier 5 Tier 4 Tier 4 Tier 5 Tier 4 Tier 6 Tier 6 Tier 6 Tier 7 Tier 7 Tier 7 Tier 9		Laboratory Tests	\$15		\$15	
Imaging (CTPPET scens, NRIss) Tier 1 Tier 1 Tier 2 Tier 2 Tier 3 Tier 3 Tier 3 Tier 3 Tier 4 Tier 4 Tier 4 Tier 4 Tier 5 Tier 4 Tier 4 Tier 5 Tier 4 Tier 4 Tier 5 Tier 4 Tier 6 Tier 6 Tier 6 Tier 7 Tier 7 Tier 7 Tier 9	Tests	X-rays and Diagnostic Imaging	\$30		\$30	
Ter 1 Ter 2 Ter 2 Ter 3 Ter 3 Ter 3 Ter 4 Town to 5550 per 1 Town to 5550 per 1 Ter 3 Ter 3 Ter 4 Town to 5550 per 1 Town town town town town town town town t						
True 1 True 2 S15 S25 S25 S25 S25 S25 S25 S25 S25 S25 S2		imaging (CT/PET scans, MRIs)	10%		\$75	
True 1 True 2 S15 S25 S25 S25 S25 S25 S25 S25 S25 S25 S2		Tier 1	\$5		\$5	
Tier 3 \$25 \$25 \$25 \$25 \$25 \$25 \$25 \$25 \$25 \$25						
Treat it items or condition Titer 3 Titer 4 Titer 5 Ti	Drugs to	Tier 2	\$15		\$15	
Tier 4 10% up to \$250 per script 10% up to \$	treat illness					
Outpatient Surgery facility fee (e.g., ASC) Prispician/europeon fees Outpatient visit Need Immediate attention Urgent care Need Immediate attention Urgent care Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, merital health, mediate health, and substance use) Prysician/europeon health and substance use disorder outpatient office value which substance use disorder outpatient attention Mental health, and substance use disorder outpatient office value and substance use) Pregnancy Help recovering or other spacial health and substance use disorder outpatient office value and proconception visits Pregnancy Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skillod nursing care Child Dental Diagnosts and Child Dental Basic Services Preventive Child Dental Basic Services Child Dental Basic Services Priorational Child Dental Basic Services Priorational Child Dental Basic Services Priorational Child Dental Major Services Child Dental Basic Services Priorational Child Dental Major Services Child Dental Major Services Not Covered Procedured to the Covered Priorated Major Services Priorational Services Priorational Services Services Priorationa	or condition	Tier 3	\$25		\$25	
Surgary facility fee (e.g., ASC) Physician/surgaron fees Outpatient visit Emergency room facility fee (walved if admitted) Emergency room facility fee (walved if admitted) Emergency room physician fee (valved if admitted) No charge Medical transportation (including emergency and non-emergency) Urgent care Facility fee (e.g. hespital room) for impatient stay (including labor and delivery, mental health, and autotrance use) Physician/surgaen fee Mental health, neath health, and substance use disorder outpatient office valids health, neath health, and autotrance use disorder outpatient office valids health neads Pregnancy Prenatal care and preconception vieits No charge Home health care (cost share per viait) 10% S20 Salide nursing care Home health care (cost share per viait) 10% S20 Salide nursing care 10% Silide nursing care 10% Silide nursing care 10% Silide nursing care Child bental bental care (cost share per viait) Child bental Basic Basic Basic Basic Services Child bental Basic Services Child bental Major Assertive Child bental Major and Child bental Major Services Child Dental Major Services			10% up to \$250 per		10% up to \$250 per	
Outpatient visit Emergency room facility fee (walved if admitted) Emergency room facility fee (walved if admitted) Emergency room physician fee (walved if admitted) Emergency room physician fee (walved if admitted) Nedical transportation (including emergency and non-emergency) It grant care Hospital stay Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and autotrance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Mental health, and substance use disorder outpatient office visits S15 S15 S15 S15 S15 S15 S15 S1		Tier 4				
Outpatient visit Emergency room facility fee (walved if admitted) Emergency room facility fee (walved if admitted) Emergency room physician fee (walved if admitted) Emergency room physician fee (walved if admitted) Nedical transportation (including emergency and non-emergency) It grant care Hospital stay Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and autotrance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Mental health, and substance use disorder outpatient office visits S15 S15 S15 S15 S15 S15 S15 S1		Surgery facility fee (e.g., ASC)	10%		\$100	
Pregrancy Presental care and preconception visits Pregrancy Presental care and preconception visits Pregrancy Holip recovering or characteristics and services Preventive Child Dental Diagnostic and Preventive - Cleaning	Outpatient					
Emergency room facility fee (walved if admitted) No charge Medical transportation (including emergency and non-emergency) Wedical transportation (including emergency and non-emergency) Wedical transportation (including emergency and non-emergency) Wetal tention Urgent care Facility fee (e.g. hospital room) for inpotient stay (including labor and delivery, mental health, and substance use) Montal health, phenavioral health and substance use disorder outpatient office vists Wental/behavioral health and substance use disorder outpatient office vists Pregnancy Prematal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Outpatient Rehabilitation and Habilitation services No charge Responsive × Cleaning Preventive Cleaning Not Covered No		Physician/surgeon fees	10%		\$25	
Emergency room physician fee (waived if admitted) No charge No charge Medical transportation (including emergency and non-emergency) Medical transportation (including emergency and non-emergency) Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health, and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Pregnancy Prenatal care and preconception visits No charge		Outpatient visit	10%		10%	
Emergency room physician fee (waived if admitted) No charge No charge Medical transportation (including emergency and non-emergency) Medical transportation (including emergency and non-emergency) Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health, and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Pregnancy Prenatal care and preconception visits No charge		Emergency room facility fee (waived if admitted)	\$150		\$150	
Need immediate attention Medical transportation (including emergency and non-emergency) \$150						
Immediate attention Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Still Sills Stills St		Emergency room physician fee (waived if admitted)	No charge		No charge	
Urgent care		Medical transportation (including emergency and non-emergency)	\$150		\$150	
Urgent care Urgent care Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Montal health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Pregnancy Prenstal care and preconception visits No charge No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Outpatient Rehabilitation and Habilitation services 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 Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Variay Saalants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Prosthodontics Prost						
Hospital stay		Henry and				
Hospital stay delivery, mental health, and substance use) Physician/surgeon fee Mental health, or substance abuse needs and preconception visits Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stilled nursing care Unable needs experies Durable medical equipment Hospice service Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Child Dental Basic Services Child Dental Major Space Maintainers - Fixed Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Prosthodontics Prosthodontics Prosthodontics Medically seressary orthodontics Medically seressary orthodontics Medically seressary orthodontics		Urgent care	\$15		\$15	
Hospital stay delivery, mental health, and substance use) Physician/surgeon fee Mental health, or substance abuse needs and preconception visits Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stilled nursing care Unable needs experies Durable medical equipment Hospice service Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Child Dental Basic Services Child Dental Major Space Maintainers - Fixed Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Prosthodontics Prosthodontics Prosthodontics Medically seressary orthodontics Medically seressary orthodontics Medically seressary orthodontics						
Mental health, behavioral health and substance use disorder outpatient office visits behavioral health or substance use disorder outpatient office visits when the visits and services when the proconception visits and services when the proconception visits and services when the proconception visits when the process when the proconception visits when the proconception visits when the process when the process when the proconception visits when the process when			10%			
Mental health, behavioral health and substance use disorder outpatient office visits behavioral health, or substance abuse needs Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient S15	Hospital stay	delivery, mental health, and substance use)	1070		5 days	
health, behavioral health and substance use disorder other outpatient onice visits behavioral health, or substance abuse needs terms and services Pregnancy Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) 10% \$20 Unpatient Rehabilitation and Habilitation services \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$1		Physician/surgeon fee	10%		No charge	
health, behavioral health, or substance abuse needs Pregnancy Pr	Mental	Mental/behavioral health and substance use disorder outpatient office				
Neath, or substance abuse needs Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services No charge No charge			\$15		\$15	
substance abuse needs letters and services letters and services Pregnancy Prenatal care and preconception visits No charge No charge No charge Prenatal care and preconception visits No charge No charge No charge Prenatal care and preconception visits No charge No charge No charge No charge Preventive Preventive Preventive Procedures Periodontics Provices Prosthodontics Oral Surgery Child Dental Basic Services Not Covered Procedures Periodontics Oral Surgery Child Dental Basic Services Procedures Periodontics Not Covered Prosthodontics Oral Surgery Child Dental Basic Services Procedures Periodontics Not Covered Prosthodontics Oral Surgery Child Dental Basic Services Periodontics Not Covered Prosthodontics Oral Surgery Child Dental Basic Cardial Major Services Periodontics Not Covered Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered Prosthodontics Not Covered Prosth						
Pregnancy Pregnancy Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stifs Stifs Precovering or other special health needs Durable medical equipment Hospice service Child eye Care Child eye Care Child Dental Diagnostic and Preventive Child Dental Basic Services Restorative Procedures Periodontics Crowns and Casts Endodontics Periodontics Oral Surgery Child Dental Basic Services Prosthodontics Oral Surgery Child Dental Child Dental Basic Services Prosthodontics Oral Surgery Child Dental Child Dental Child Dental Basic Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically precessary orthodontics Oral Surgery Child Medically precessary orthodontics Oral Surgery Child Medically precessary orthodontics One Covered Not Covered			\$15		\$15	
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye Care Child Dental Basic Services Crowns and Casts Endodontics Crowns and Casts Endodontics Oral Surgery Child Medically necessary outhodoutics Oral Surgery Child Medically necessary outhodoutics Not Covered	abuse needs	items and services	·		·	
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Corowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Oral Surgery Child Medically necessary orthodontics Not Covered	Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Corowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Oral Surgery Child Medically necessary orthodontics Not Covered		Home health care (cost share per visit)	10%		\$20	
recovering or other special health needs Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Oral Surgery Child Medically necessary orthodontics Oral Surgery Skilled nursing care 10% S\$150 per day up to 5 days 10% S150 per day up to 5 days 10% Stodays 10% No charge Not Covered Not Covered Not Covered Not Covered					·	
ther special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care I pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered		Outpatient Rehabilitation and Habilitation services	\$15		\$15	
health needs health needs Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services Child Dental Medically recessary orthodontics Oral Surgery Child Medically recessary orthodontics Oral Surgery Child Medically recessary orthodontics Oral Surgery No charge Not Covered Not Covered Not Covered Not Covered		Skilled nursing care	10%			
Durable medical equipment 10%		·	4007			
Child eye care Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered			10%		10%	
Thild Dental Basic Periodontics Child Dental Basic Periodontics Child Dental Major Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered		Hospice service	No charge		No charge	
Thild Dental Basic Periodontics Child Dental Basic Periodontics Child Dental Major Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Child ava	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Dental Major Services Prosthodontics Prosthodontics Oral Surgery Child Medically peressary orthodontics Not Covered N			_		_	
Child Dental Diagnostic and Preventive - Cleaning Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered			ino charge		ino criarge	
Child Dental Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered		Oral Exam				
Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered		Preventive - Cleaning				
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered		Preventive - X-ray				
Preventive Sealants per 1 doin Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered		•	Not Covered		Not Covered	
Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Crowns and Casts Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered		Sealants per Tooth				
Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered		Topical Fluoride Application				
Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered		Space Maintainers - Fixed				
Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Child Dontal	·				
Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Not Covered Not Covered			Not Covered		Not Covered	
Child Dental Major Periodontics (other than maintenance) Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered Not Covered		Periodontal Maintenance Services				
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered Not Covered Not Covered		Crowns and Casts				
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered Not Covered Not Covered		Endadantics				
Services Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered						
Prosthodontics Oral Surgery Child Medically pecessary orthodontics Not Covered Net Covered		Periodontics (other than maintenance)	Not Covered		Not Covered	
Child Medically necessary orthodontics Not Covered Not Covered	Oct vices	Prosthodontics				
Child Medically necessary orthodontics Not Covered Not Covered		Oral Surgery				
	Child	• •				
Urtnoaontics	Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	í
tuarial Value - A	V Coloulator	90.7%		88.8%	
tuariai value - A	Plan design includes a deductible?	90.7% No		00.0% No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0/\$0/\$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$		\$0/\$0/\$	
	Individual Out-of-pocket maximum	\$4,500	-	\$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
zvent	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit				
AIIIIC VISIC		\$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	
Orugs to	Tier 2	\$25		\$20	
reat illness or condition	Tier 3	\$40		\$30	
ir condition	nor o				
	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	
oci vioco	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed	Medical transportation (including emergency and non-emergency)	, and the second		\$150	
mmediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
ttention					
	Urgent care	\$15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	400/		\$250 per day up to	
lospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
lental ealth,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$20	
oehavioral	visits	Ψισ		ΨΣΟ	
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$20	
abuse needs	items and services	φισ		φ20	
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	
21.11	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	
nd Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not O		Not O	
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major		Not Covered		Not Covered	
Major Services	Periodontics (other than maintenance)	NOL COVERED		NOT COVETED	
	Prosthodontics				
01.11.7	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
	WO	0.4.004			
tuarial Value - A		81.9% No.		80.1% No	
	Plan design includes a deductible? Integrated Individual deductible	No \$0		\$0	
	Integrated muividual deductible Integrated Family deductible	\$0 \$0		\$0 \$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	co.
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$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	
	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	\$35		\$35	
Health care	011	***			
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	
or condition	1613	φου		φου	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpotiont	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	
mmediate		* ===		V	
attention	Urgent eare	#2 5		Ф 25	
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		\$350 per day up to	
Hospital stay	delivery, mental health, and substance use)	2007		5 days	
Mantal	Physician/surgeon fee	30%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
behavioral health, or	VISIG				
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	
	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	
Child eye care	Eye exam	No charge		No charge	
Jaio	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Obilita	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Course !		Not Course !	
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	
	Prosthodontics				
				1	1
	Oral Surgery				

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Pla	n	CCSB-only Gold Copay Plan	
Actuarial Value - A	V Calculator	78.9%		80.5%	
Actuariai value - A	Plan design includes a deductible?	Yes, Medical/Pharm	acv	Yes, Medical/Phari	macv
	Integrated Individual deductible	N/A	40,	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	N/A N/A		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	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 \$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
					X
	Tier 1	\$15		\$15	
Drugs to	Tier 2	\$50		\$40	
treat illness or condition	Tier 3	\$80		\$70	
		, , ,			
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient services	Physician/surgeon fees	20%		\$35	
301 11000	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	х	\$250	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	x	\$250	X
immediate attention					
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X	\$600 per day up to 5 days	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee				,
Mental		20%	X	No charge	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
behavioral health, or	Montal/hohaviaral hoalth and substance use disorder other autrations				
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
recovering or other special	Skilled nursing care	20%	×	\$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	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics		2510100		2515153	

Summary of	of Be	enefits	and	Coverage

Common	risa ranniy plan. individual deductible	IV/A	Deductible
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
	Family Out-of-pocket maximum	\$17,500	
	Individual Out-of-pocket maximum	\$8,750	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$9,500 / \$170 / \$0)
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,750 / \$85 / \$0	
	Integrated Family deductible	N/A	
	Integrated Individual deductible	N/A	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу
Actuarial Value - A	AV Calculator	71.6%	
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Plan

Common			Deductibl
Medical Event	Service Type	Member Cost Share	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	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$16	Pharmad deductib
Drugs to	Tier 2	\$60	Pharma deductib
treat illness or condition	Tier 3	\$90	Pharma
	Tion 4	20% up to \$250 per script	deductib Pharma
	Tier 4	after pharmacy deductible	deductib
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$400	
Need	Emergency room physician fee (waived if admitted)	No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$45	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	
Mental 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 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		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed Restorative Procedures		
Basic Services	Periodontal Maintenance Services	Not Covered	
Sei vices	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

-	enefits and Coverage e amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plar		CCSB-only Silver Copay Plan	
		Comounance i iu		Copa, i iaii	
Actuarial Value - A		71.9%		71.7%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0		\$2,500 / \$300 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$6	
	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
LVCIII	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	
T	Laboratory Tests	\$55		\$55	
Tests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	Х	\$300	X
	Tier 1	\$20		\$19	
Drugs to	Tier 2	\$75	Pharmacy deductible	\$85	Pharmacy deductible
treat illness	Tier 3	\$ 105	Pharmacy	\$110	Pharmacy
or condition	Tiel 3		deductible		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%	X	30%	х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	35%	X	30%	X
attention					
	Urgent care	\$55		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	X	40%	Х
Hospital stay	Physician/surgeon fee	35%	X	40%	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$55		\$55	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	055		055	
abuse needs	items and services	\$55		\$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
recovering or other special	Skilled nursing care	35%	X	40%	x
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				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
rieventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
A	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					

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	
tuarial Value - ^	V Calculator	74 70/	
uarial Value - A	V Calculator Plan design includes a deductible?	71.7% Yes, integr	
	Integrated Individual deductible	\$2,700 integ	
Integrated Family deductible		\$5,400 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$7,200)
	Family Out-of-pocket maximum	\$14,40	0
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		
Common Medical	Service Type	Member Cost Share	
Event	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%	Х
Гests	X-rays and Diagnostic Imaging	25%	×
	Imaging (CT/PET scans, MRIs)	25%	x
	Tier 1	25% up to \$250 per	×
		script 25% up to \$250 per	
Drugs to	Tier 2	script	X
reat illness or condition	Tier 3	25% up to \$250 per script	×
	Tier 4	25% up to \$250 per	x
	Surgery facility fee (e.g., ASC)	script	X
Outpatient			
services	Physician/surgeon fees	25%	X
	Outpatient visit	25%	X
	Emergency room facility fee (waived if admitted)	25%	X
	Emergency room physician fee (waived if admitted)	0%	X
Need immediate	Medical transportation (including emergency and non-emergency)	25%	X
attention			
	Urgent care	25%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	050/	
Hospital stay	delivery, mental health, and substance use)	25%	Х
	Physician/surgeon fee	25%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	25%	×
behavioral health, or	Note		
substance	Mental/behavioral health and substance use disorder other outpatient items and services	25%	х
abuse needs		NI= =!	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	X
Help	Outpatient Rehabilitation and Habilitation services	25%	X
recovering or other special	Skilled nursing care	25%	×
health needs	Durable medical equipment	25%	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)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	Not Covered	
Drovent!	Topical Fluoride Application		
Preventive			
Preventive	Space Maintainers - Fixed		
Preventive Child Dental	Space Maintainers - Fixed Restorative Procedures		
		Not Covered	
Child Dental Basic	Restorative Procedures	Not Covered	
Child Dental Basic	Restorative Procedures Periodontal Maintenance Services	Not Covered	
Child Dental Basic Services Child Dental	Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics		
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	Not Covered Not Covered	
Child Dental Basic Services Child Dental Major	Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics		

Health care provider's office or clinic visit Tests Drugs to treat illness or condition Outpatient services	Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	94.9% Yes, Medical/F N/A N/A \$75 / \$0 \$150 / \$0 \$900 \$1,800 N/A N/A Member Cost Share \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script 10%	Pharmacy / \$0 / \$0	87.9% Yes, Medical/Pharm N/A N/A \$800 / \$25 / \$0 \$1,600 / \$50 / \$0 \$3,000 \$6,000 N/A N/A Member Cost Share \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	
Common Medical Event Health care provider's office or clinic visit For the services Common Great illness or condition Coutpatient services	Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	Yes, Medical/F N/A N/A \$75 / \$0 \$150 / \$0 \$900 \$1,800 N/A N/A Member Cost Share \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	Pharmacy / \$0 / \$0 Deductible	Yes, Medical/Pharm N/A N/A \$800 / \$25 / \$0 \$1,600 / \$50 / \$0 \$3,000 \$6,000 N/A N/A Member Cost Share \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$25 \$45	Pharmac deductible Pharmac deduc
Medical Event Fleath care provider's office or clinic visit Fleats Orugs to reat illness or condition Outpatient services	Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	N/A N/A N/A \$75 / \$0 \$150 / \$0 \$900 \$1,800 N/A N/A Member Cost Share \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	/ \$0 / \$0) Deductible	N/A N/A N/A \$800 / \$25 / \$0 \$1,600 / \$50 / \$0 \$3,000 \$6,000 N/A N/A Member Cost Share \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$25 \$45	Pharmac deductibl Pharmac deductible
ledical vent File Content Con	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	N/A \$75 / \$0 \$150 / \$0 \$900 \$1,800 N/A N/A Member Cost Share \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	/ \$0 Deductible	N/A \$800 / \$25 / \$0 \$1,600 / \$50 / \$0 \$3,000 \$6,000 N/A N/A Member Cost Share \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	Pharmac deductibl Pharmac deductibl Pharmac
ledical vent Fealth care rovider's ffice or linic visit Ests Prugs to eat illness r condition Support	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$150 / \$0 \$900 \$1,800 N/A N/A Member Cost Share \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	/ \$0 Deductible	\$1,600 / \$50 / \$0 \$3,000 \$6,000 N/A N/A N/A Member Cost Share \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	Pharmac deductible Pharmac deduc
dedical event felealth care provider's ffice or dinic visit fests forugs to reat illness or condition forugation forugati	Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$900 \$1,800 N/A N/A N/A Member Cost Share \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	Deductible	\$3,000 \$6,000 N/A N/A N/A Member Cost Share \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	Pharmac deductible Pharmac deduc
dedical event felealth care provider's ffice or dinic visit fests forugs to reat illness or condition forugation forugati	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$1,800 N/A N/A N/A Member Cost Share \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	Deductible	\$6,000 N/A N/A Member Cost Share \$15 \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	Pharmac deductibl Pharmac deductibl Pharmac
dedical event felealth care provider's ffice or dinic visit fests forugs to reat illness or condition forugation forugati	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	N/A N/A N/A Member Cost Share \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script	Deductible	N/A N/A N/A Member Cost Share \$15 \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	Pharmac deductibl Pharmac deductibl Pharmac
Medical Event Fleath care provider's office or clinic visit Fleats Orugs to reat illness or condition Outpatient services	Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	N/A Member Cost Share \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		N/A Member Cost Share \$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	Pharmac deductibl Pharmac deductibl Pharmac
Medical Event Fleath care provider's office or clinic visit Fleats Orugs to reat illness or condition Outpatient services	Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	## Member Cost Share \$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		\$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	Pharmac deductibl Pharmac deductibl Pharmac
Medical Event Felealth care provider's office or clinic visit Fests Orugs to reat illness or condition Outpatient services	Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$5 \$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		\$15 \$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	Pharmac deductibl Pharmac deductibl Pharmac
dealth care provider's office or shifting visit of state of the shifting visit of the sh	Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$5 \$8 No charge \$8 \$8 \$50 \$3 \$10 \$15		\$15 \$25 No charge \$20 \$40 \$100 \$5 \$25	deductibl Pharmac deductibl Pharmac
rovider's ffice or linic visit sests prugs to reat illness r condition support of the condition of the c	Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$8 No charge \$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		\$25 No charge \$20 \$40 \$100 \$5 \$25 \$45	deductibl Pharmac deductibl Pharmac
linic visit Figure 1 Figure 2 Figure 2 Figure 2 Figure 2 Figure 3 Figure 3 Figure 3 Figure 4 Fig	Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	No charge \$8 \$8 \$50 \$3 \$10 \$15		No charge \$20 \$40 \$100 \$5 \$25 \$45	deductible Pharmacted deductible Pharmacted
Prugs to reat illness r condition	Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	No charge \$8 \$8 \$50 \$3 \$10 \$15		No charge \$20 \$40 \$100 \$5 \$25 \$45	deductible Pharmace deductible Pharmace
ests :	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$8 \$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		\$20 \$40 \$100 \$5 \$25 \$45	deductible Pharmace deductible Pharmace
ests 2	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$8 \$50 \$3 \$10 \$15 10% up to \$150 per script		\$40 \$100 \$5 \$25 \$45	deductible Pharmace deductible Pharmace
rugs to eat illness r condition	Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$50 \$3 \$10 \$15 10% up to \$150 per script		\$100 \$5 \$25 \$45	deductibl Pharmac deductibl Pharmac
rugs to reat illness r condition	Tier 1 Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$3 \$10 \$15 10% up to \$150 per script		\$5 \$25 \$45	deductible Pharmacted deductible Pharmacted
orugs to reat illness r condition	Tier 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$10 \$15 10% up to \$150 per script		\$25 \$45	deductible Pharmace deductible Pharmace
eat illness r condition	Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	\$15 10% up to \$150 per script		\$45	deductibl Pharmad
r condition	Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees	10% up to \$150 per script			
outpatient Fervices	Surgery facility fee (e.g., ASC) Physician/surgeon fees	script		15% up to \$150 per	
Outpatient Fervices	Surgery facility fee (e.g., ASC) Physician/surgeon fees	script			Pharmac
Outpatient Services	Physician/surgeon fees	10%		15% up to \$150 per script	deductibl
ervices				15%	
(10%		15%	
	Outpatient visit	10%		15%	
F	Emergency room facility fee (waived if admitted)	\$50		\$150	
E	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$30		\$75	
nmediate ttention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	Х	25%	Х
iospitai stay	delivery, mental health, and substance use) Physician/surgeon fee				^
Iontal		10%		25%	
ealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ehavioral nealth, or					
ubstance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
ecovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
other special	Skilled nursing care	10%	Χ	25%	Х
[Durable medical equipment	10%		15%	
H	Hospice service	No charge		No charge	
Jillia 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 Diagnostic	Preventive - X-ray	Net O		N=4 Ov vv l	
and	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
5	Space Maintainers - Fixed				
	Restorative Procedures				
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
E	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Calculator Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out—of—pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2 Tier 3	73.9% Yes, Medical/Pharm N/A N/A \$4,750 / \$30 / \$0 \$9,500 / \$60 / \$0 \$7,250 \$14,500 N/A N/A Member Cost Share \$45 \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16 \$55)
Common Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out—of—pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	Yes, Medical/Pharm N/A N/A \$4,750 / \$30 / \$0 \$9,500 / \$60 / \$0 \$7,250 \$14,500 N/A N/A Member Cost Share \$45 \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Deductib Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	N/A N/A N/A \$4,750 / \$30 / \$0 \$9,500 / \$60 / \$0 \$7,250 \$14,500 N/A N/A Member Cost Share \$45 \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Deductib Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	N/A \$4,750 / \$30 / \$0 \$9,500 / \$60 / \$0 \$7,250 \$14,500 N/A N/A Member Cost Share \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Deductib Applies
Medical Event Health care provider's office or clinic visit Fests Drugs to creat illness or condition	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible HSA family plan: Individual deductible Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$4,750 / \$30 / \$0 \$9,500 / \$60 / \$0 \$7,250 \$14,500 N/A N/A Member Cost Share \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Deductib Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$9,500 / \$60 / \$0 \$7,250 \$14,500 N/A N/A N/A Member Cost Share \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Deductib Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$7,250 \$14,500 N/A N/A Member Cost Share \$45 \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Deductib Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$14,500 N/A N/A N/A Member Cost Share \$45 \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	N/A Member Cost Share \$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Service Type Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Applies
Medical Event Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$45 \$45 \$85 No charge \$50 \$90 \$325 \$16	Applies
Health care provider's office or clinic visit Tests Drugs to treat illness or condition	Other practitioner office visit Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$45 \$85 No charge \$50 \$90 \$325 \$16	
provider's office or clinic visit Tests Drugs to treat illness or condition	Specialist visit Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$85 No charge \$50 \$90 \$325 \$16	
Tests Drugs to treat illness or condition	Preventive care/ screening/ immunization Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	No charge \$50 \$90 \$325 \$16	
Tests Drugs to treat illness or condition	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$50 \$90 \$325 \$16	
Tests Drugs to treat illness or condition	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$50 \$90 \$325 \$16	
Drugs to treat illness or condition	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$90 \$325 \$16	
Drugs to treat illness or condition	Imaging (CT/PET scans, MRIs) Tier 1 Tier 2	\$325 \$16	
Drugs to treat illness or condition	Tier 2	\$16	
Drugs to treat illness or condition	Tier 2		
treat illness or condition		\$55	
or condition	Tier 3		Pharma deductib
		\$85	Pharma
	Tier 4	20% up to \$250 per script after pharmacy deductible	deductil Pharma deductil
	Surgery facility fee (e.g., ASC)	20%	deddciil
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	
	Medical transportation (including emergency and non-emergency)	, and the second	
immediate attention	medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$4 5	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х
	Physician/surgeon fee	30%	
	Mental/behavioral health and substance use disorder outpatient office visits	\$45	
	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
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
coro	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	140 Glarge	
	Preventive - Cleaning		
Child Dental	Preventive - Clearing Preventive - X-ray		
and		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Basic	Restorative Procedures	Not Covered	
30.11.000	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
Child	Oral Surgery		

9.5 EHB

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
uarial Value - A		64.7%		64.2%	
Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		Yes, Medical/Pharmacy N/A N/A		Yes, integrated \$7,000 integrated \$14,000 integrated	
		\$12,600 / \$1,000 / \$0		N/A	
			Individual Out-of-pocket maximum	\$8,200	
	Family Out-of-pocket maximum	\$16,400		\$14,000	
	HSA plan: Self-only coverage deductible	N/A		\$7,000	
	HSA family plan: Individual deductible	N/A	I	\$7,000	
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	\$65	After 1st three non- preventive visits	0%	Х
Health care	Other practitioner office visit	\$65	After 1st three non-	0%	x
provider's office or	·	φοσ	preventive visits After 1st three non-	0 78	
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	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	\$18	Pharmacy Deductible	0%	×
	Tier 2	40% up to \$500 per script after	Pharmacy	0%	x
Drugs to treat illness	1101 2	pharmacy deductible	Deductible	U%	
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 deductible	Pharmacy Deductible	0%	x
	Surgery facility fee (e.g., ASC)	40%	x	0%	Х
Outpatient	Physician/surgeon fees	40%	x	0%	X
services	Outpatient visit	40%	×	0%	x
	Emergency room facility fee (waived if admitted)	40%	×	0%	×
	Emergency room physician fee (waived if admitted)	No charge		0%	×
Need	Medical transportation (including emergency and non-emergency)	40%	X	0%	×
immediate attention	Urgent care		After 1st three non-		×
	Orgenic care	\$65	preventive visits	0%	^
llaan'i s	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	Х
Hospital stay	Physician/surgeon fee	40%	×	0%	X
Mental	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-		
health, behavioral	visits	\$65	preventive visits	0%	X
health, or 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	
	Home health care (cost share per visit)	40%	×	0%	×
delp	Outpatient Rehabilitation and Habilitation services	\$65		0%	×
lelp ecovering or	Skilled nursing care	40%	X	0%	×
other special nealth needs	-				
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	Х
Child eye	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	
nd reventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	0010100			
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child					

Summary of	Benefits and	Coverage

Summary of Benefits and Coverage						
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catas	trophic Plan			
Actuarial Value - A	W Calculator					
Actuariai value - A	Plan design includes a deductible?	Yes.	integrated			
	Integrated Individual deductible		0 integrated			
	Integrated Family deductible	\$18,20	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		\$9,100			
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	1	N/A			
	HSA family plan: Individual deductible		N/A			
Common Medical	Service Type	Member Cost	Deductible Applies			
Event		Share	After 1st three non-			
Health care	Primary care visit to treat an injury, illness, or condition	0%	preventive visits			
provider's office or	Other practitioner office visit	0%	After 1st three non- preventive visits			
clinic visit	Specialist visit	0%	×			
	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			
Drugs to	Tier 2	0%	X			
treat illness or condition	Tier 3	0%	X			
	Tier 4	0%	x			
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	0%	X X			
services	Outpatient visit	0%	X			
	Emergency room facility fee (waived if admitted)	0%	X			
	Emergency room physician fee (waived if admitted)	No charge	,			
Need	Medical transportation (including emergency and non-emergency)	0%	X			
immediate attention						
	Urgent care	0%	After 1st three non- preventive visits			
			•			
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X			
	Physician/surgeon fee	0%	X			
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits			
behavioral health, or			preventive visits			
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%	X			
Help	Outpatient Rehabilitation and Habilitation services	0%	X			
recovering or other special	Skilled nursing care	0%	X			
health needs	Durable medical equipment	0%	×			
	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 Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covered				
and Preventive	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed Restorative Procedures					
Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered				
CSI VICES	Crowns and Casts					
OF 114 D	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	Not Covered				
Services	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	Not Covered				

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver 94 100%-150%		Silver 87 Plan 150%-200% FPL	-
huarial V-I	V Calculator	05.10		22.22	
uarial Value - A	V Calculator Plan design includes a deductible?	95.1% Ves Medical/F		88.6%	and a second
Integrated Individual deductible Integrated Family deductible		Yes, Medical/Pharmacy N/A N/A		Yes, Medical/Pharmacy N/A	
				N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$900		\$3,000	
	Family Out-of-pocket maximum	\$1,800)	\$6,000	
	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	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
lealth care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
ests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
ruge to	Tier 2	\$10		\$25	
rugs to reat illness	Tier 3				
r condition	Her 3	\$15		\$45	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
	Surgery facility fee (e.g., ASC)	10%		15%	
Outpatient services	Physician/surgeon fees	10%		15%	
sei vices	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed	Medical transportation (including emergency and non-emergency)	\$30		\$75	
mmediate		φοσ		4. 5	
itterition	Urgent care	\$5		\$15	
		ΨΟ		\$10	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		25%	
lospital stay	Physician/surgeon fee	10%		25%	
/lental	Mental/behavioral health and substance use disorder outpatient office				
ealth, ehavioral	visits	\$5		\$15	
ealth, or substance	Mental/behavioral health and substance use disorder other outpatient	0.5			
abuse needs	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%		25%	
ealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
hild ove	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	5.14190		. to shargo	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Child Dont-L	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	Medically necessary orthodontics	Not Covered		Not Covered	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver 80 Plan 200%-600% FPL	
	V2.1.1		
tuarial Value - A		81.0%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm N/A	acy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$4,900	
	Family Out-of-pocket maximum	\$9,800	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$30	
Health care provider's	Other practitioner office visit	\$30	
office or clinic visit	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$80	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$10	
Drugs to	Tier 2	\$40	
treat illness	Tier 3	\$70	
or condition			
	Tier 4	20% up to \$250 per script after pharmacy deductible	
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 attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$30	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	
	Physician/surgeon fee	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$30	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$30	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Heln	Outpatient Rehabilitation and Habilitation services	\$30	
Help recovering or	Skilled nursing care	30%	
other special health needs	-		
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
Jaio	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Correct	
Basic 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		

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.
	Drugs that are biologics and drugs that the Food and
	Drug Administration (FDA) or drug manufacturer requires to
4	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.