Covered California 2022 Patient-Centered Benefit Plan Designs¹

Final Board-approved May 20, 2021^{2, 3}

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

² Clerical adjustment made to Silver 70 Urgent Care cost share to \$35 on March 23, 2021

³ Updates made to Catastrophic Plan Out-of-Pocket maximum and deductibles to reflect federal final rule for 2022.



	efits and Coverage			Individual anhu D	latinum
mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
tuarial Value - AV		91.6%		89.3%	
luariai value - Av	Plan design includes a deductible?	91.0% 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 / \$	
	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	Deductil Applie
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
provider's	Other practitioner office visit	\$15		\$15	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Fests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15		\$15	
liness or condition	Tier 3	\$25		\$25	
Jonation					
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Dutpatient 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	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate		\$130		φ130	
attention	Urgent care	\$15		\$15	
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services	No shares		No shares	
Pregnancy	Prenatal care and preconception visits Home health care (cost share per visit)	No charge		No charge	
				\$20	
lelp ecovering or	Outpatient Rehabilitation and Habilitation services	\$15		\$15 \$150 per day up to	
other special	Skilled nursing care	10%		\$150 per day up to 5 days	
nealth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child 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 2022 Dental	
Services	Periodontal Maintenance Services			Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See 2022 Dental Copay Schedule	
Services	Prosthodontics			Copay Conedule	
	Oral Surgery				

2022 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021

Oral Surgery

Medically necessary orthodontics

Child

Orth

CCSB-only Summary of Benefits and Coverage CCSB-only Platinum Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 88.3% 90.5% Plan design includes a deductible? No No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental 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 Member Cost Share Member Cost Share Deductible Applies Deductible Applies Service Type Event Primary care visit to treat an injury, illness, or condition \$15 \$20 Health care Other practitioner office visit \$15 \$20 provider's office or clinic visit Specialist visit \$30 \$30 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$15 \$20 Tests X-rays and Diagnostic Imaging \$30 \$30 Imaging (CT/PET scans, MRIs) 10% \$100 Tier 1 \$10 \$5 Tier 2 \$20 \$25 Drugs to treat illn condition Tier 3 \$30 \$40 10% up to \$250 per 10% up to \$250 per Tier 4 script script Surgery facility fee (e.g., ASC) 10% \$100 Outpatient services \$25 Physician/surgeon fees 10% Outpatient visit 10% 10% Emergency room facility fee (waived if admitted) \$200 \$150 Emergency room physician fee (waived if admitted) No charge No charge Need Medical transportation (including emergency and non-emergency) \$150 \$150 immediate attention Urgent care \$15 \$20 Facility fee (e.g. hospital room) for inpatient stay (including labor and \$250 per day up to 10% delivery, mental health, and substance use) 5 days Hospital stay Physician/surgeon fee 10% No charge Mental Mental/behavioral health and substance use disorder outpatient office health. \$15 \$20 visits behavioral health, or substance Mental/behavioral health and substance use disorder other outpatient \$15 \$20 items and services abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$20 Help recovering or other special health needs \$150 per day up to Skilled nursing care 10% 5 days Durable medical equipment 10% 10% Hospice service No charge No charge Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-rav Diagnostic and No charge No charge Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures See 2022 Dental Basic Services 20% Copay Schedule Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental See 2022 Dental Periodontics (other than maintenance) 50% Major Copay Schedule Services Prosthodontics

50%

\$1,000

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance I		Individual-only Copay Pla	
tuarial Value - AV	/ Calculator	81.9%		78.0%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$8,200		\$8,200	
	Family Out-of-pocket maximum	\$16,400		\$16,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appli
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
lealth care provider's	Other practitioner office visit	\$35		\$35	
office or					
linic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
lests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$150	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
Iness or condition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Dutpatient	Physician/surgeon fees	20%		\$40	
ervices					
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Veed	Medical transportation (including emergency and non-emergency)	\$250		\$250	
mmediate attention					
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%		\$600 per day up to	
lospital stay	delivery, mental health, and substance use)	20%		5 days	
	Physician/surgeon fee	20%		No charge	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office	\$35		\$35	
behavioral	visits	φοσ		\$55	
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient	\$35		\$35	
buse needs	items and services	\$ 00		φοσ	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
lelp	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
ecovering or other special	Skilled nursing care	20%		\$300 per day up to 5 days	
nealth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
	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				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	. to sharge		. to sharge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 0000 D	
Basic	Periodontal Maintenance Services	20%		See 2022 Dental Copay Schedule	
Services					
	Crowns and Casts				
Child Dental	Endodontics			Sac 2000 D	
Vlajor	Periodontics (other than maintenance)	50%		See 2022 Dental Copay Schedule	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%			

2022 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Pla	n	CCSB-only Gold Copay Plan	
tuarial Value - A\	V Calculator	78.0%		79.4%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acv	Yes, Medical/Pharr	macv
	Integrated Individual deductible	N/A	uoy	N/A	nuoy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out–of–pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A	Daduatible	N/A	Deductib
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
provider's	Other practitioner office visit	\$25		\$35	
office or clinic visit	Specialist visit	\$50		\$55	
chine visit					
_	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Fests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х
	Tier 1	\$15		\$15	
	Tier 2	\$50		\$40	
Drugs to treat Ilness or		ψυυ		φ +∪	
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	
Sel VICES	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	х	\$250	х
	Emergency room physician fee (waived if admitted)		~		~
Nood		No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	20%	Х	\$250	Х
attention	Urgent care	\$25		\$35	
-	Facility fee (e.g. hospital room) for inpatient stay (including labor and	00%	v		v
Hospital stay	delivery, mental health, and substance use)	20%	Х	\$600 per day up to 5 days	Х
	Physician/surgeon fee	20%	х	No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
- ognalloy	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%	х	\$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	5 -		5 -	
	Preventive - Cleaning				
Child Dental	·				
Diagnostic and	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2022 Dental Copay Schedule	
Services	Periodontal Maintenance Services			GUIRUUR	
	Crowns and Casts				
	Endodontics				
Child Dental				0 0000 Dantal Oranau	
Major	Periodontics (other than maintenance)	50%		See 2022 Dental Copay Schedule	
Major		50%		See 2022 Dental Copay Schedule	
Child Dental Major Services	Periodontics (other than maintenance)	50%			

Individual-only Silver Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator 71.1% Plan design includes a deductible? Yes, Medical/Pharmacy Integrated Individual deductible N/A Integrated Family deductible N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$3,700 / \$10 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$7,400 / \$20 / \$0 Individual Out-of-pocket maximum \$8,200 Family Out-of-pocket maximum \$16.400 HSA plan: Self-only coverage deductible N/A HSA family plan. Individual deductible N/A Common Medical Deductible Applies Service Type Member Cost Share Event Primary care visit to treat an injury, illness, or condition \$35 Health care Other practitioner office visit \$35 provider's office or clinic visit Specialist visit \$70 Preventive care/ screening/ immunization No charge Laboratory Tests \$40 Tests X-rays and Diagnostic Imaging \$85 Imaging (CT/PET scans, MRIs) \$325 Pharmacy deductible Tier 1 \$15 Pharmacy Tier 2 \$55 Drugs to treat deductible illne Pharmacy condition Tier 3 \$85 deductible 20% up to \$250 per script Pharmacy Tier 4 after pharmacy deductible deductible Surgery facility fee (e.g., ASC) 20% Outpatient services Physician/surgeon fees 20% 20% Outpatient visit Emergency room facility fee (waived if admitted) \$400 Emergency room physician fee (waived if admitted) No charge Need Medical transportation (including emergency and non-emergency) \$250 immediate attention Urgent care \$35 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 20% Х Hospital stay Physician/surgeon fee 20% Mental Mental/behavioral health and substance use disorder outpatient office health. \$35 visits behavioral health, or substance Mental/behavioral health and substance use disorder other outpatient \$35 items and services abuse needs Prenatal care and preconception visits Pregnancy No charge Home health care (cost share per visit) \$45 Outpatient Rehabilitation and Habilitation services \$35 Help recovering or other special health needs Skilled nursing care 20% х Durable medical equipment 20% Hospice service No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-rav Diagnostic No charge and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Basic Services 20% Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental 50% Periodontics (other than maintenance) Major Services Prosthodontics Oral Surgery Child Medically necessary orthodontics 50%

2022 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: May 20, 2021

•	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plar	1	CCSB-only Silver Copay Plan	
tuarial Value - A\	/ Calculator	71.4%		70.8%	
	Plan design includes a deductible?		асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	,	N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0)	\$2,250 / \$300 / \$(0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0)	\$4,500 / \$600 / \$6	0
	Individual Out-of-pocket maximum	\$8,200		\$8,200	
	Family Out-of-pocket maximum	\$16,400		\$16,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$50		\$55	
lealth care	Other practitioner office visit	\$50		\$55	
provider's		\$50		\$00 	
linic visit	Specialist visit	\$85		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$50		\$55	
ests	X-rays and Diagnostic Imaging	\$85		\$90	
	Imaging (CT/PET scans, MRIs)	30%	х	\$300	х
					~
	Tier 1	\$17		\$17	
Drugs to treat	Tier 2	\$70	Pharmacy	\$80	Pharma
liness or	Tier 2	A	deductible Pharmacy	A	deductil Pharma
ondition	Tier 3	\$100	deductible	\$110	deductil
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharma deductil
	Surgery facility fee (e.g., ASC)	30%	Х	30%	х
Outpatient services	Physician/surgeon fees	30%		30%	
	Outpatient visit	30%		30%	
	Emergency room facility fee (waived if admitted)	30%	х	30%	х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	30%	х	30%	х
mmediate attention			^		^
	Urgent care	\$50		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	х	30%	х
Hospital stay	Physician/surgeon fee	30%	х	30%	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$50		\$55	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$55	
abuse needs	Prenatal care and preconception visits	No charge		No charge	
Pregnancy		No charge		-	
	Home health care (cost share per visit)	30%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$55	
recovering or other special	Skilled nursing care	30%	х	30%	х
health needs	Durable medical equipment	30%		30%	
	Hospice service	No charge		No charge	
Child ove	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	i to silai go		i to sharge	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2022 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental		500/		See 2022 Dental Copay	
Major Services	Periodontics (other than maintenance)	50%		Schedule	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

2022 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	•
tuarial Value - A	/ Calculator	71.8%	
	Plan design includes a deductible?	Yes, integr	rated
	Integrated Individual deductible	\$2,500 integ	
	Integrated Family deductible	\$5,000 integ	-
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out–of–pocket maximum	\$6,850)
	Family Out-of-pocket maximum	\$13,70	0
	HSA plan: Self-only coverage deductible	\$2,500)
	HSA family plan: Individual deductible	See endr	note
Common Medical Event	Service Type	Member Cost Share	Deductible Ap
	Primary care visit to treat an injury, illness, or condition	20%	х
Health care provider's	Other practitioner office visit	20%	х
office or clinic visit	Specialist visit	20%	x
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	20%	x
Tests	X-rays and Diagnostic Imaging	20%	x
	Imaging (CT/PET scans, MRIs)	20%	x
		20 % 20% up to \$250 per	
	Tier 1	script	x
Drugs to treat	Tier 2	20% up to \$250 per script	x
illness or condition	Tier 3	20% up to \$250 per script	x
	Tier 4	20% up to \$250 per script	х
	Surgery facility fee (e.g., ASC)	20%	х
Outpatient services	Physician/surgeon fees	20%	х
501 11003	Outpatient visit	20%	x
	Emergency room facility fee (waived if admitted)	20%	х
	Emergency room physician fee (waived if admitted)	0%	x
Need	Medical transportation (including emergency and non-emergency)	20%	x
immediate attention		2078	~
	Urgent care	20%	х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	x
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	x
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	20%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	20%	x
Pregnancy	Prenatal care and preconception visits	No charge	
- 3	Home health care (cost share per visit)	20%	х
Help recovering or	Outpatient Rehabilitation and Habilitation services	20%	x
other special	Skilled nursing care	20%	x
health needs	Durable medical equipment	20%	х
	Hospice service	0%	x
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	-	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive			
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child			

2022 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: May 20, 2021 Summary of Benefits and Coverage

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	-
tuarial Value - A	V Calculator	94.7%		87.8%	
	Plan design includes a deductible?	Yes, Medical/F		Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	namacy	N/A	lacy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$800/ \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 / \$0		\$1,600/ \$0 / \$0	
	Individual Out-of-pocket maximum	\$800		\$2,850	
	Family Out-of-pocket maximum	\$1,600	1	\$5,700	
	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	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or					
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Drugs to treat	Tier 2	\$10		\$25	
liness or	Tior 2	<i>.</i>		A	
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	Physician/surgeon fees	10%		15%	
services					
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	1001	X	150/	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%	Х	15%	х
Mental	Mental/behavioral health and substance use disorder outpatient office	1070		1070	
health, behavioral health, or	visits	\$5		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
dolp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or					
other special health needs	Skilled nursing care	10%	Х	15%	Х
neann 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 and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
20111003	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Prosthodontics Oral Surgery				

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	-
tuarial Value - A	/ Calculator	73.4%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 / \$10 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$20 / \$0)
	Individual Out–of–pocket maximum	\$6,300	
	Family Out-of-pocket maximum	\$12,600	
	HSA plan: Self-only coverage deductible	N/A	
•	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or		6 70	
clinic visit	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$40	
Fests	X-rays and Diagnostic Imaging	\$85	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	Pharma
		ψισ	deductik
Drugs to treat	Tier 2	\$55	Pharma deductit
liness or condition	Tier 3	\$85	Pharma
			deductik
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductit
	Surgery facility fee (e.g., ASC)	20%	
Dutpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
_	Emergency room facility fee (waived if admitted)		
		\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
attention	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	x
Hospital stay	delivery, mental health, and substance use)	20%	^
	Physician/surgeon fee	20%	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge	
- eghanoy	Home health care (cost share per visit)	\$40	
	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or			
other special	Skilled nursing care	20%	Х
nealth needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	Ŭ	
	Preventive - Cleaning		
Child Dental			
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
	Periodontal Maintenance Services	2070	
Services	Crowns and Casts		
Services			
	Endodontics		
Child Dental		50%	
Services Child Dental Major Services	Periodontics (other than maintenance)	50%	
Child Dental Major		50%	

2022 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021

Summary of Benefits and Coverage

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plan	n
tuorial Value A	/ Colouistor	64.8%		64.6%	
tuarial Value - A			201		ted
	Plan design includes a deductible?	Yes, Medical/Phar	nacy	Yes, integrat	
	Integrated Individual deductible Integrated Family deductible	N/A N/A		\$7,000 integra \$14,000 integr	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 / \$	0.4	۹۱4,000 integr N/A	aleu
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$12,600 / \$1,000	/ ⊅0	N/A See endnot	
		\$8,200			
	Family Out-of-pocket maximum	\$16,400 N/A		See endnot \$7,000	le
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		\$7,000	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductik
Event			After 1st three non-		Applie
Health care	Primary care visit to treat an injury, illness, or condition	\$65	preventive visits	0%	Х
provider's	Other practitioner office visit	\$65	After 1st three non- preventive visits	0%	Х
office or clinic visit	Specialist visit	\$95	After 1st three non-	0%	x
chine visit			preventive visits		^
_	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%	х	0%	х
	Tier 1	\$18	Pharmacy Deductible	0%	х
		40% up to \$500 per script after	Pharmacy		
Drugs to treat	Tier 2	pharmacy deductible	Deductible	0%	Х
Iness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	x
		pharmacy deductible	Deductible		
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
	Surgery facility fee (e.g., ASC)	40%	x	0%	х
Dutpatient	Physician/surgeon fees				
services		40%	X	0%	Х
	Outpatient visit	40%	Х	0%	Х
	Emergency room facility fee (waived if admitted)	40%	x	0%	Х
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need	Medical transportation (including emergency and non-emergency)	40%	x	0%	х
mmediate attention					
	Urgent care	\$65	After 1st three non- preventive visits	0%	х
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and			201	X
Hospital stay	delivery, mental health, and substance use)	40%	X	0%	Х
	Physician/surgeon fee	40%	х	0%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office	6 05	After 1st three non-	0%	V
health, behavioral	visits	\$65	preventive visits	0%	X
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$65	X	0%	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	х	0%	х
			^		
lelp	Outpatient Rehabilitation and Habilitation services	\$65		0%	Х
ecovering or other special	Skilled nursing care	40%	х	0%	х
nealth needs	Durable medical equipment	40%	x	0%	х
	Hospice service	No charge		0%	х
Child over	Eye exam	No charge		No charge	
Child eye are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
		i to onalige		No onarge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
nd Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic	Periodontal Maintenance Services	20%		20%	
Services					
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
					1

2022 Patient-Centered Benefit Plan Designs 10.0 EHB Date: May 20, 2021

Summary of Benefits and Coverage

tuarial Value - A\	/ Calculator Plan design includes a deductible?	Voc	integrated
	Integrated Individual deductible		-
	Integrated Harvidal deductible		0 integrated)0 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	ψΠ,-Ι	N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	:	\$8,700
	Family Out-of-pocket maximum		17,400
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical	Service Type	Member Cost Share	Deductible Applie
Event	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no preventive visits
Health care	Other practitioner office visit	0%	After 1st three no
provider's office or		0%	preventive visits
clinic visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	х
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1		
		0%	х
Drugs to treat illness or	Tier 2	0%	Х
condition	Tier 3	0%	х
	Tier 4	0%	х
	Surgery facility fee (e.g., ASC)	0%	х
Outpatient services	Physician/surgeon fees	0%	Х
	Outpatient visit	0%	х
	Emergency room facility fee (waived if admitted)	0%	х
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	0%	х
immediate attention			
attention	Urgent care	0%	After 1st three no preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	х
Hospital stay	delivery, mental health, and substance use)		
	Physician/surgeon fee	0%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three no preventive visits
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Holp	Outpatient Rehabilitation and Habilitation services	0%	x
Help recovering or			
other special health needs	Skilled nursing care	0%	X
	Durable medical equipment	0%	х
	Hospice service	0%	х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	х
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed		
Basic	Restorative Procedures	0%	х
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	0%	х
Services	Prosthodontics		
	Oral Surgery		
Child			



Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance		Copay Pla	
Actuarial Value - A	V Calculator	91.6%		89.3%	
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A	-	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	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%		\$30	
	Tier 1	\$5		\$5	
Drugs to treat	Tier 2	\$15		\$15	
illness or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate		\$150		\$150	
attention	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use)			5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	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				
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		Net Course 1		Net Course 1	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2022 Patient-Centered Benefit Plan Designs 9.5 EHB Date: May 20, 2021

Oral Surgery

Medically necessary orthodontics

Child

Orth

CCSB-only CCSB-only Summary of Benefits and Coverage Platinum Platinum Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan Copay Plan Actuarial Value - AV Calculator 88.3% 90.5% Plan design includes a deductible? No No Integrated Individual deductible \$0 \$0 Integrated Family deductible \$0 \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental 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 Member Cost Share Member Cost Share Deductible Applies Deductible Applies Service Type Event Primary care visit to treat an injury, illness, or condition \$15 \$20 Health care Other practitioner office visit \$15 \$20 provider's office or clinic visit Specialist visit \$30 \$30 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$15 \$20 Tests X-rays and Diagnostic Imaging \$30 \$30 Imaging (CT/PET scans, MRIs) 10% \$100 Tier 1 \$10 \$5 Tier 2 \$20 \$25 Drugs to treat illn condition Tier 3 \$40 \$30 10% up to \$250 per 10% up to \$250 per Tier 4 script script Surgery facility fee (e.g., ASC) 10% \$100 Outpatient services Physician/surgeon fees 10% \$25 Outpatient visit 10% 10% Emergency room facility fee (waived if admitted) \$200 \$150 Emergency room physician fee (waived if admitted) No charge No charge Need Medical transportation (including emergency and non-emergency) \$150 \$150 immediate attention Urgent care \$20 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and \$250 per day up to 10% delivery, mental health, and substance use) 5 days Hospital stay Physician/surgeon fee 10% No charge Mental Mental/behavioral health and substance use disorder outpatient office health. \$15 \$20 visits behavioral health, or substance Mental/behavioral health and substance use disorder other outpatient \$15 \$20 items and services abuse needs Prenatal care and preconception visits Pregnancy No charge No charge Home health care (cost share per visit) 10% \$20 Outpatient Rehabilitation and Habilitation services \$15 \$20 Help recovering or other special health needs \$150 per day up to Skilled nursing care 10% 5 days Durable medical equipment 10% 10% Hospice service No charge No charge Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-rav Diagnostic and Not Covered Not Covered Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Not Covered Basic Periodontal Maintenance Services Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) Not Covered Not Covered Major Services Prosthodontics

Not Covered

Not Covered

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
uarial Value - AV	/ Calculator	81.9%		78.0%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
	Individual Out–of–pocket maximum	\$8,200		\$8,200	
	Family Out-of-pocket maximum	\$16,400		\$16,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applie
lealth care	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
provider's	Other practitioner office visit	\$35		\$35	
linic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
ests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	20%		\$150	
	Tier 1	\$15		\$15	
	-				
rugs to treat	Tier 2	\$55		\$55	
Iness or ondition	Tier 3	\$80		\$80	
	Tier 4	20% up to \$250 per		20% up to \$250 per	
		script		script	
	Surgery facility fee (e.g., ASC)	20%		\$300	
Outpatient ervices	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	
leed		-		-	
mmediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
ittention	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%		\$600 per day up to	
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	2001/		5 days	
fautal.	Filysicial/surgeon iee	20%		No charge	
lental lealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
ehavioral	VISICS				
ealth, or substance subse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
lelp	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
ecovering or				\$300 per day up to	
ther special ealth needs	Skilled nursing care	20%		5 days	
earth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
hild Dental	Preventive - Cleaning				
liagnostic	Preventive - X-ray	Not Covered		Not Covered	
nd Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
lasic ervices	Periodontal Maintenance Services	Not Covered		Not Covered	
CIVICES					
	Crowns and Casts				
hild Dental	Endodontics				
/lajor	Periodontics (other than maintenance)	Not Covered		Not Covered	
lond					
Services	Prosthodontics				
Services	Prosthodontics Oral Surgery				

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Oral Surgery

Medically necessary orthodontics

Child Orthodo

-	nefits and Coverage	CCSB-only		CCSB-only		
tuarial Value - AV	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Pla	n	Gold Copay Plan		
tuarial Value - A						
		78.0%		79.4%		
	Plan design includes a deductible?	Yes, Medical/Pharm	асу	Yes, Medical/Pharr	macy	
	Integrated Individual deductible	N/A		N/A		
	Integrated Family deductible	N/A \$350 / \$0 / \$0		N/A \$250 / \$0 / \$0		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0 \$700 / \$0 / \$0		\$500 / \$0 / \$0		
	Individual Out-of-pocket maximum	\$7,800		\$7,800		
	Family Out-of-pocket maximum	\$15,600		\$15,600		
	HSA plan: Self-only coverage deductible	N/A		N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
lealth care	Other practitioner office visit	\$25		\$35		
provider's		φ20		φοσ		
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
ests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	х	
	Tier 1	\$15		\$15		
Drugs to treat Ilness or	Tier 2	\$50		\$40		
condition	Tier 3	\$80		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300	х	
Outpatient	Physician/surgeon fees	20%		\$35		
services	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	x	\$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		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	х	\$600 per day up to 5 days	х	
noophar olay	Physician/surgeon fee	20%	x	No charge		
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35		
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35		
abuse needs		No oborgo		No oborgo		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
other special	Skilled nursing care	20%	x	\$300 per day up to 5 days	Х	
nooleh noodo	Durable medical equipment	20%		20%		
lealth needs	Hospice service	No charge		No charge		
leann neeus						
	Eye exam	No charge		No charge		
Child eye	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge No charge		No charge No charge		
Child eye		-		_		
Child eye	1 pair of glasses per year (or contact lenses in lieu of glasses)	-		_		
Child eye are Child Dental	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge		
Child eye care Child Dental Diagnostic and	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray	-		_		
Child eye care Child Dental Diagnostic and	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	No charge		No charge		
Child eye care Child Dental Diagnostic and	1 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	No charge		No charge		
Child eye care Child Dental Diagnostic and Preventive	1 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	No charge		No charge		
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	1 pair of glasses per year (or contact lenses in lieu of glasses)Oral ExamPreventive - CleaningPreventive - X-raySealants per ToothTopical Fluoride ApplicationSpace Maintainers - FixedRestorative Procedures	No charge		No charge		
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	1 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 Restorative Procedures Periodontal Maintenance Services	No charge Not Covered		No charge		
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	1 pair of glasses per year (or contact lenses in lieu of glasses)Oral ExamPreventive - CleaningPreventive - X-raySealants per ToothTopical Fluoride ApplicationSpace Maintainers - FixedRestorative ProceduresPeriodontal Maintenance ServicesCrowns and Casts	No charge Not Covered		No charge		
health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	1 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 Restorative Procedures Periodontal Maintenance Services	No charge Not Covered		No charge		

Not Covered

Not Covered

Individual-only Silver Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator 71.1% Plan design includes a deductible? Yes, Medical/Pharmacy Integrated Individual deductible N/A Integrated Family deductible N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$3,700 / \$10 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$7,400 / \$20 / \$0 Individual Out-of-pocket maximum \$8,200 Family Out-of-pocket maximum \$16.400 HSA plan: Self-only coverage deductible N/A HSA family plan. Individual deductible N/A Common Medical Deductible Applies Service Type Member Cost Share Event Primary care visit to treat an injury, illness, or condition \$35 Health care Other practitioner office visit \$35 provider's office or clinic visit Specialist visit \$70 Preventive care/ screening/ immunization No charge Laboratory Tests \$40 Tests X-rays and Diagnostic Imaging \$85 Imaging (CT/PET scans, MRIs) \$325 Pharmacy deductible Tier 1 \$15 Pharmacy Tier 2 \$55 Drugs to treat deductible illne Pharmacy condition Tier 3 \$85 deductible 20% up to \$250 per script Pharmacy Tier 4 after pharmacy deductible deductible Surgery facility fee (e.g., ASC) 20% Outpatient services Physician/surgeon fees 20% 20% Outpatient visit Emergency room facility fee (waived if admitted) \$400 Emergency room physician fee (waived if admitted) No charge Need Medical transportation (including emergency and non-emergency) \$250 immediate attention Urgent care \$35 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:starses}$ 20% Х Hospital stay Physician/surgeon fee 20% Mental Mental/behavioral health and substance use disorder outpatient office health. \$35 visits behavioral health, or substance Mental/behavioral health and substance use disorder other outpatient \$35 items and services abuse needs Prenatal care and preconception visits Pregnancy No charge Home health care (cost share per visit) \$45 Outpatient Rehabilitation and Habilitation services \$35 Help recovering or other special health needs Skilled nursing care 20% х Durable medical equipment 20% Hospice service No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-rav Diagnostic Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Basic Periodontal Maintenance Services Services Crowns and Casts Endodontics Child Dental Periodontics (other than maintenance) Not Covered Major Services Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered

2022 Patient-Centered Benefit Plan Designs

9.5 EHB Date: May 20, 2021

Immary of Benefits and Coverage mber Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB-only Silver Coinsurance Plan		CCSB-only Silver		
				Copay Plan		
tuarial Value - A	V Calculator	71.4%		70.8%		
	Plan design includes a deductible?	Yes, Medical/Pharmacy		Yes, Medical/Pharmacy		
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$300 / \$0		\$2,250 / \$300 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$600 / \$0		\$4,500 / \$600 / \$0		
	Individual Out–of–pocket maximum	\$8,200		\$8,200		
	Family Out-of-pocket maximum	\$16,400		\$16,400		
	HSA plan: Self-only coverage deductible	N/A		N/A		
Common	HSA family plan: Individual deductible	N/A		N/A		
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies	
	Primary care visit to treat an injury, illness, or condition	\$50		\$55		
Health care provider's	Other practitioner office visit	\$50		\$55		
office or						
clinic visit	Specialist visit	\$85		\$90		
_	Preventive care/ screening/ immunization	No charge		No charge		
Taata	Laboratory Tests	\$50		\$55		
Tests	X-rays and Diagnostic Imaging	\$85	×.	\$90		
	Imaging (CT/PET scans, MRIs)	30%	Х	\$300	Х	
	Tier 1	\$17		\$17		
Drugs to treat	Tier 2	\$70	Pharmacy deductible	\$80	Pharma deductik	
illness or	Tier 3	¢100	Pharmacy	¢140	Pharma	
condition		\$100	deductible	\$110	deductib	
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharma deductit	
	Surgery facility fee (e.g., ASC)	30%	х	30%	Х	
Outpatient services	Physician/surgeon fees	30%		30%		
	Outpatient visit	30%		30%		
	Emergency room facility fee (waived if admitted)	30%	х	30%	Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	30%	х	30%	х	
immediate attention						
	Urgent care	\$50		\$55		
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
Hospital stay	delivery, mental health, and substance use)	30%	Х	30%	Х	
	Physician/surgeon fee	30%	х	30%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$50		\$55		
behavioral	visits					
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		\$55		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	30%		\$45		
Help	Outpatient Rehabilitation and Habilitation services	\$50		\$55		
recovering or	Skilled nursing care	30%	х	30%	х	
other special health needs	Durable medical equipment	30%	~	30%	~	
	Hospice service	30% No charge		30% No charge		
	Eye exam	No charge		No charge		
Child eye care	Lye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)					
	Oral Exam	No charge		No charge		
	Preventive - Cleaning					
Child Dental	Preventive - X-ray					
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed Restorative Procedures					
Basic		Not Covered		Not Covered		
Services	Periodontal Maintenance Services					
	Crowns and Casts					
Child Dental						
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics Oral Surgery					

2022 Patient-Centered Benefit Plan Designs 9.5 EHB Date: May 20, 2021

Summary of Benefits and Coverage

Child Orthod

Medically necessary orthodontics

Not Covered

Silver HDHP Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator 71.8% Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2,500 integrated Integrated Family deductible \$5,000 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum \$6,850 Family Out-of-pocket maximum \$13,700 HSA plan: Self-only coverage deductible \$2,500 HSA family plan: Individual deductible See endnote Common Medical Service Type Member Cost Share Deductible Applies Event Primary care visit to treat an injury, illness, or condition 20% Х Health care provider's office or Other practitioner office visit 20% Х clinic visit Specialist visit 20% х Preventive care/ screening/ immunization No charge Laboratory Tests 20% Х Tests X-rays and Diagnostic Imaging 20% Х Imaging (CT/PET scans, MRIs) 20% Х 20% up to \$250 per Tier 1 х script 20% up to \$250 per Tier 2 Х Drugs to treat script illnes S 01 20% up to \$250 per condition Tier 3 Х script 20% up to \$250 per Tier 4 х script Surgery facility fee (e.g., ASC) 20% х Outpatient services Physician/surgeon fees 20% х Outpatient visit 20% х Emergency room facility fee (waived if admitted) 20% Х Emergency room physician fee (waived if admitted) 0% х Need Medical transportation (including emergency and non-emergency) 20% Х immediate attention Urgent care 20% Х Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) $% \label{eq:factor}$ 20% Х Hospital stay Physician/surgeon fee 20% Х Mental Mental/behavioral health and substance use disorder outpatient office 20% health. Х visits behavioral health, or substance Mental/behavioral health and substance use disorder other outpatient 20% Х items and services abuse needs Prenatal care and preconception visits Pregnancy No charge Home health care (cost share per visit) 20% х Outpatient Rehabilitation and Habilitation services 20% Х Help recovering or other special health needs Skilled nursing care 20% х Durable medical equipment 20% Х Hospice service 0% х Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-rav Diagnostic Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Basic Periodontal Maintenance Services Services Crowns and Casts Endodontics Child Dental Not Covered Major Periodontics (other than maintenance) Services Prosthodontics Oral Surgery

CCSB-only

2022 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: May 20, 2021 Summary of Benefits and Co

mmary of Benefits and Coverage nber Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL		
uarial Value - A\	/ Calculator	94.7%)	87.8%		
	Plan design includes a deductible?			87.8% Yes, Medical/Pharmacy		
	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/ \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental			\$1,600/ \$0 / \$0 \$2,850		
	Individual Out–of–pocket maximum					
	Family Out-of-pocket maximum	\$1,600)	\$5,700		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A		
Common		Member Cost Deductible		Deduct		
Medical Event	Service Type	Share	Applies	Member Cost Share	Applies	
lealth care	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
provider's	Other practitioner office visit	\$5		\$15		
linic visit	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$8		\$20		
Fests	X-rays and Diagnostic Imaging	\$8		\$40		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
	Tier 1	\$3				
		φ٥		\$5		
Drugs to treat	Tier 2	\$10		\$25		
Iness or ondition	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%		
Dutpatient	Physician/surgeon fees	10%		15%		
ervices	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		4 30		ψισ		
attention	l transf eare	05		045		
	Urgent care	\$5		\$15		
_	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
lospital stay	delivery, mental health, and substance use)	10%	Х	15%	Х	
	Physician/surgeon fee	10%		15%		
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15		
ehavioral	visits	ψ υ		V IO		
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15		
buse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	\$3		\$15		
loin	Outpatient Rehabilitation and Habilitation services	\$5		\$15		
lelp ecovering or	Skilled nursing care	10%	х	15%	x	
other special lealth needs			^			
	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
child eye are	Eye exam	No charge		No charge		
al C	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	Net O:				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
	Crowns and Casts					
	Endodontics					
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Periodonilics (other than maintenance)				1	
Child Dental Major Services	Υ Υ					
Major	Prosthodontics Oral Surgery					

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL		
tuarial Value - A\	/ Calculator	73.4%		
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	
	Integrated Individual deductible	N/A	,	
	Integrated Family deductible	N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$3,700 / \$10 / \$0)	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$7,400 / \$20 / \$0)	
	Individual Out–of–pocket maximum	\$6,300		
	Family Out-of-pocket maximum	\$12,600		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		
Common Medical	Service Type	Member Cost Share	Deductib	
Event	Primary care visit to treat an injury, illness, or condition	\$35	Applies	
Health care				
provider's	Other practitioner office visit	\$35		
clinic visit	Specialist visit	\$70		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$40		
Fests	X-rays and Diagnostic Imaging	\$85		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$15	Pharma	
		÷	deductik	
Drugs to treat	Tier 2	\$55	Pharma deductit	
Ilness or condition	Tier 3	\$85	Pharma deductit	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma	
_	Surgery facility fee (e.g., ASC)	20%	doddolli	
Outpatient	Physician/surgeon fees			
services		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	\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	х	
Hospital stay	delivery, mental health, and substance use)		~	
Manufal .	Physician/surgeon fee	20%		
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$40		
lelp	Outpatient Rehabilitation and Habilitation services	\$35		
ecovering or	Skilled nursing care	20%	х	
other special nealth needs	-	20%	~	
	Durable medical equipment			
	Hospice service	No charge		
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray	Not Covered		
and Preventive	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Sasic Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			

2022 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: May 20, 2021

mber Cost Share	amounts describe the Enrollee's out of pocket costs. Bronze Plan			Bronze HDHP Plan		
tuarial Value 1		64.8%		64 60/		
iarial Value - AV Calculator		04.8% Yes, Medical/Pharr		64.6%		
	Plan design includes a deductible?	res, medical/Phan N/A	пасу	Yes, integrated		
Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		\$7,000 integrated \$14,000 integrated		
		\$6,300 / \$500 / \$0		N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 / \$1,000		N/A		
	Individual Out-of-pocket maximum	\$12,000 / \$1,000 / \$0 \$8,200 \$16,400 N/A		See endnote See endnote \$7,000		
	Family Out-of-pocket maximum					
	HSA plan: Self-only coverage deductible					
	HSA family plan: Individual deductible	N/A		\$7,000		
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie	
Event	Primary care visit to treat an injury, illness, or condition	\$65	After 1st three non-	0%	x	
lealth care provider's	Other practitioner office visit	\$65	preventive visits After 1st three non-	0%	x	
office or		A 07	preventive visits After 1st three non-			
linic visit	Specialist visit	\$95	preventive visits	0%	Х	
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$40		0%	Х	
ests	X-rays and Diagnostic Imaging	40%	х	0%	х	
	Imaging (CT/PET scans, MRIs)	40%	x	0%	х	
	Tier 1	\$18	Pharmacy Deductible	0%	х	
					~	
orugs to treat	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х	
Iness or ondition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	x	
		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy			
	Tier 4	pharmacy deductible	Deductible	0%	Х	
	Surgery facility fee (e.g., ASC)	40%	x	0%	х	
outpatient ervices	Physician/surgeon fees	40%	х	0%	х	
	Outpatient visit	40%	x	0%	x	
	Emergency room facility fee (waived if admitted)	40%	x	0%	х	
	Emergency room physician fee (waived if admitted)	No charge		0%	x	
Need immediate attention	Medical transportation (including emergency and non-emergency)	40%	v	0%	x	
			X After 1st three non-			
	Urgent care	\$65	preventive visits	0%	X	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	x	0%	х	
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	40%	x	0%	x	
Mental		1070			~	
nealth, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$65	After 1st three non- preventive visits	0%	х	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$65	x	0%	x	
regnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	40%	x	0%	х	
	Outpatient Rehabilitation and Habilitation services	\$65		0%	x	
lelp ecovering or						
ther special	Skilled nursing care	40%	X	0%	Х	
ealth needs	Durable medical equipment	40%	х	0%	x	
	Hospice service	No charge		0%	х	
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
hild Dental	Preventive - X-ray					
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered		
	Topical Fluoride Application					
	Space Maintainers - Fixed					
hild Dental asic	Restorative Procedures	Not Covered		Not Covered		
Bervices	Periodontal Maintenance Services			NUL COVELED		
UCI VICES	Crowns and Casts					
	Endodontics			1		
		Not Covered		Not Covered		
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Child Dental Major Services		Not Covered		Not Covered		

Catastrophic Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$8,700 integrated Integrated Family deductible \$17,400 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A Individual Out-of-pocket maximum \$8,700 Family Out-of-pocket maximum \$17,400 HSA plan: Self-only coverage deductible N/A HSA family plan. Individual deductible N/A Common Medical Member Cost Share Service Type Deductible Applies Event After 1st three non-Primary care visit to treat an injury, illness, or condition 0% preventive visits Health care After 1st three nonprovider's office or clinic visit Other practitioner office visit 0% preventive visits Specialist visit 0% х Preventive care/ screening/ immunization No charge Laboratory Tests 0% х Tests X-rays and Diagnostic Imaging 0% х Imaging (CT/PET scans, MRIs) 0% х Tier 1 0% х Tier 2 0% Х Drugs to treat illn condition Tier 3 0% х Tier 4 0% х Surgery facility fee (e.g., ASC) 0% х Outpatient services Physician/surgeon fees 0% х Outpatient visit 0% х Emergency room facility fee (waived if admitted) 0% х Emergency room physician fee (waived if admitted) No charge Need Medical transportation (including emergency and non-emergency) 0% х immediate attention After 1st three non-Urgent care 0% preventive visits Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 0% х Hospital stay Physician/surgeon fee 0% х Mental Mental/behavioral health and substance use disorder outpatient office After 1st three nonhealth. 0% visits preventive visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient substance 0% х items and services abuse needs Prenatal care and preconception visits Pregnancy No charge Home health care (cost share per visit) 0% х Outpatient Rehabilitation and Habilitation services 0% Х Help recovering or other special health needs Skilled nursing care 0% х Durable medical equipment 0% х Hospice service 0% х Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) 0% х Oral Exam Preventive - Cleaning Child Dental Preventive - X-rav Diagnostic Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Major Periodontics (other than maintenance) Not Covered Services Prosthodontics Oral Surgery Child Orthog Medically necessary orthodontics Not Covered

Endnotes to Covered California 2022 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 2022 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.
- 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 § 1397.656; 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 2022 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) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these patient-centered benefit plan designs if necessary for compliance with MHPAEA.
- 22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
- 23) Drug tiers are defined as follows:

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

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The Bronze and Bronze HDHP are contingent upon meeting the actuarial value requirements in state law. The out-of-pocket maximum in the Bronze HDHP shall be equal to the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2022 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.