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COVERED CALIFORNIA™

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$4,000	$4,000

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$20		$20	
	Specialist visit		$40		$40	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Generic drugs		$5		$5	
	Preferred brand drugs		$15		$15	
	Non-preferred brand drugs		$25		$25	
	Specialty drugs		10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%			
Need immediate attention	Emergency room services (waived if admitted)		$150		$150	
	Emergency medical transportation		$150		$150	
	Urgent care		$40		$40	
Hospital stay	Facility fee (e.g. hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$20		$20	
	Mental/Behavioral health inpatient services		10%		$250 per day up to 5 days	
	Substance use disorder outpatient services		$20		$20	
	Substance use disorder inpatient services		10%		$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		$250 per day up to 5 days	
		Professional	10%			
Help recovering or other special health needs	Home health care		10%		$20	
	Outpatient Rehabilitation services		$20		$20	
	Outpatient Habilitation services		$20		$20	
	Skilled nursing care		10%		$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Coverd		Not Covered	
	Gingivectomy per Quad				Not Covered	
	Extraction- Single Tooth Exposed Root or				Not Covered	
	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
Individual Overall deductible	$0	$0
Other individual deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$30		$30	
	Specialist visit		$50		$50	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$30		$30	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50		$50	
	Non-preferred brand drugs		$70		$70	
	Specialty drugs		20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%			
Need immediate attention	Emergency room services (waived if admitted)		$250		$250	
	Emergency medical transportation		$250		$250	
	Urgent care		$60		$60	
Hospital stay	Facility fee (e.g. hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$30		$30	
	Mental/Behavioral health inpatient services		20%		$600 per day up to 5 days	
	Substance use disorder outpatient services		$30		$30	
	Substance use disorder inpatient services		20%		$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%		$600 per day up to 5 days	
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$30	
	Outpatient Rehabilitation services		$30		$30	
	Outpatient Habilitation services		$30		$30	
	Skilled nursing care		20%		$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Coverd		Not Covered	
	Gingivectomy per Quad				Not Covered	
	Extraction- Single Tooth Exposed Root or				Not Covered	
	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	Individual Silver Coinsurance Plan	Individual Silver Copay Plan
Actuarial Value - AV Calculator	70.30%	69.90%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	$2,000	$2,000
Brand Drugs	$250	$250
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$45		$45	
	Specialist visit		$65		$65	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$45		$45	
	X-rays and Diagnostic Imaging		$65		$65	
	Imaging (CT/PET scans, MRIs)		20%	X	$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50	X	$50	X
	Non-preferred brand drugs		$70	X	$70	X
	Specialty drugs		20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X	$250	X
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$90		$90	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$45		$45	
	Mental/Behavioral health inpatient services		20%	X	20%	X
	Substance use disorder outpatient services		$45		$45	
	Substance use disorder inpatient services		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Coverd		Not Covered	
	Gingivectomy per Quad				Not Covered	
	Extraction- Single Tooth Exposed Root or				Not Covered	
	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	SHOP	SHOP
	Silver Coinsurance Plan	**Silver Copay Plan**
Actuarial Value - AV Calculator	71.50%	71.00%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	$1,500	$1,500
Brand Drugs	$500	$500
Dental	$0	$0
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$45		$45	
	Specialist visit		$65		$65	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$45		$45	
	X-rays and Diagnostic Imaging		$65		$65	
	Imaging (CT/PET scans, MRIs)		20%	X	$250	
Drugs to treat illness or condition	Generic drugs		$15		$15	
	Preferred brand drugs		$50	X	$50	X
	Non-preferred brand drugs		$70	X	$70	X
	Specialty drugs		20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees		20%		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X	$250	X
	Emergency medical transportation		$250	X	$250	X
	Urgent care		$90		$90	
Hospital stay	Facility fee (e.g. hospital room)		20%	X	20%	X
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$45		$45	
	Mental/Behavioral health inpatient services		20%	X	20%	X
	Substance use disorder outpatient services		$45		$45	
	Substance use disorder inpatient services		20%	X	20%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
Help recovering or other special health needs	Home health care		20%		$45	
	Outpatient Rehabilitation services		$45		$45	
	Outpatient Habilitation services		$45		$45	
	Skilled nursing care		20%	X	20%	X
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Coverd		Not Covered	
	Gingivectomy per Quad				Not Covered	
	Extraction- Single Tooth Exposed Root or				Not Covered	
	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.	**SHOP** **Silver HSA Plan**
Actuarial Value - AV Calculator	71.60%
Individual Overall deductible	$1,500 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		20%	X
	Specialist visit		20%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		20%	X
	Preferred brand drugs		20%	X
	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
Need immediate attention	Emergency room services (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	X
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		20%	X
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Outpatient Rehabilitation services		20%	X
	Outpatient Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Coverd	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.80%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat illness or condition	Generic drugs		$3		$5	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%		15%	X
	Physician/surgeon fee		10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional	10%		15%	
Help recovering or other special health needs	Home health care		10%		15%	
	Outpatient Rehabilitation services		$3		$15	
	Outpatient Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Coverd		Not Coverd	
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or					
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 200%-250% FPL
Actuarial Value - AV Calculator	rounded up to 74.0%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$35	X
	Non-preferred brand drugs		$60	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care		20%	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Coverd	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
Actuarial Value - AV Calculator	94.90%	88.00%
Individual Overall deductible	$0	N/A
Other individual deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	$0	$0
Individual Out–of–pocket maximum	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Generic drugs		$3		$5	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g. hospital room)		10%		15%	X
	Physician/surgeon fee					
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional				
Help recovering or other special health needs	Home health care		$3		$15	
	Outpatient Rehabilitation services		$3		$15	
	Outpatient Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad		Not Covered		Not Covered	
	Extraction- Single Tooth Exposed Root or		Not Covered		Not Covered	
	Extraction- Complete Bony		Not Covered		Not Covered	
	Porcelain with Metal Crown		Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.50%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	$1,600
Brand Drugs	$250
Dental	$0
Individual Out–of–pocket maximum	$5,200

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	Generic drugs		$15	
	Preferred brand drugs		$35	X
	Non-preferred brand drugs		$60	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional		
Help recovering or other special health needs	Home health care		$40	
	Outpatient Rehabilitation services		$40	
	Outpatient Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered	
	Gingivectomy per Quad		Not Covered	
	Extraction- Single Tooth Exposed Root or		Not Covered	
	Extraction- Complete Bony		Not Covered	
	Porcelain with Metal Crown		Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	60.60%	59.40%
Individual Overall deductible	$5,000 integrated Med/Rx Ded	$4,500 integrated Med/Rx
Other individual deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	$0	N/A
Individual Out–of–pocket maximum	$6,250	$6,250

Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		$60	After 1st three non-preventive visits	40%	X
	Specialist visit		$70	X	40%	X
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		30%	X	40%	X
	X-rays and Diagnostic Imaging		30%	X	40%	X
	Imaging (CT/PET scans, MRIs)		30%	X	40%	X
Drugs to treat illness or condition	Generic drugs		$15	X	40%	X
	Preferred brand drugs		$50	X	40%	X
	Non-preferred brand drugs		$75	X	40%	X
	Specialty drugs		30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)		30%	X	40%	X
	Physician/surgeon fees		30%	X	40%	X
Need immediate attention	Emergency room services (waived if admitted)		$300	X	40%	X
	Emergency medical transportation		$300	X	40%	X
	Urgent care		$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)		30%	X	40%	X
	Physician/surgeon fee		30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$60	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient services		30%	X	40%	X
	Substance use disorder outpatient services		$60	After 1st three non-preventive visits	40%	X
	Substance use disorder inpatient services		30%	X	40%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	30%	X	40%	X
		Professional	30%	X	40%	X
Help recovering or other special health needs	Home health care		30%	X	40%	X
	Outpatient Rehabilitation services		$60	X	40%	X
	Outpatient Habilitation services		$60	X	40%	X
	Skilled nursing care		30%	X	40%	X
	Durable medical equipment		30%	X	40%	X
	Hospice service		No cost share	X	No cost share	X
Child eye care	Eye exam		No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		Not Covered		Not Covered	
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or					
	Extraction- Complete Bony					
	Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

See endnotes.

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Individual Overall deductible	$6,600 integrated Med/Rx
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual Out–of–pocket maximum	$6,600

Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness		0%	After 1st three non-preventive visits
	Specialist visit		0%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Generic drugs		0%	X
	Preferred brand drugs		0%	X
	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
Need immediate attention	Emergency room services (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	After 1st three non-preventive visits
	Substance use disorder inpatient services		0%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care		0%	X
	Outpatient Rehabilitation services		0%	X
	Outpatient Habilitation services		0%	X
	Skilled nursing care		0%	X
	Durable medical equipment		0%	X
	Hospice service		No cost share	X
Child eye care	Eye exam		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)		No cost share	x
Child Dental Diagnostic and Preventive	Oral Exam		No cost share	
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar		Not Covered	
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or			
	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodontics		Not Covered	

See endnotes.

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Endnotes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family deductible and out-of-pocket maximums. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members.
2) For HDHPs linked to HSAs, an individual in a self-only coverage plan must meet a deductible of not less than the amount designated by the IRS for self-only coverage. In a family plan, each individual in the family must meet the deductible of not less than the amount designated by the IRS for family coverage, until the family deductible is met. The cost-sharing payments cannot exceed the out of pocket limits set for self-only coverage and family coverage.
3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
6) Member cost-share for oral anti-cancer drugs shall not exceed $200 per month.
7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
8) For drugs to treat an illness or condition the supply of drugs for which the copay or coinsurance applies is for the prescription term. Nothing in this note precludes a carrier from offering discounts that vary with the term of the prescription.