#### Covered California 2025 Patient-Centered Benefit Plan Designs<sup>1</sup>

Proposed

April 18, 2024

<sup>&</sup>lt;sup>1</sup> These are the Standard Benefit Plan Designs pursuant to Government Code Section 100504(c).

#### 2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: July 20, 2023 April 18, 2024

Summary of Benefits and Coverage



Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
	(0.1.1.)	04.00/		00.70/.04.6	vo./
Actuarial Value - A\		91.9%		<del>90.7%</del> <u>91.6</u>	<u>1</u> %
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$0 / \$0 / \$	:n	\$0 \$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum		0	\$4,500	U
	Family Out-of-pocket maximum			\$9,000	
	HSA plan: Self-only coverage deductible	. ,		N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care	Other practitioner office visit			\$15	
provider's office or	·	\$15			
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$7		\$7	
Druge to treet	Tier 2	\$16		\$16	
Drugs to treat	Tier 3			\$25	
condition	rier 3	\$25			
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient services	Physician/surgeon fees	10%		\$20	
Scrvices	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)				
immediate	medical transportation (moldaring emergency and non-emergency)	\$150		\$150	
attention					
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$225 per day up to	
Hospital stay	delivery, mental health, and substance use)			5 days	
	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
behavioral	VISIG				
health, or 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	Skilled nursing care	10%		\$125 per day up to	
other special health needs				5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See <del>2024</del> <u>2025</u>	
Basic		20%		Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See <del>2024</del> 2025	
Major Services	Periodontics (other than maintenance)	50%		Dental Copay Schedule	
30000	Prosthodontics			Soricule	
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

<del>-</del>	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	í	CCSB-onl Platinum Copay Pla	ĺ
tuarial Value - A\	/ Calculator	<del>91.2%</del> <u>91.3</u>	10%	<del>89.4%</del> <u>90.5</u>	0%
luariar value - A	Plan design includes a deductible?	91.278 <u>91.0</u> No	<u> </u>	No	<u> </u>
	Integrated Individual deductible	\$0		\$0	
	Integrated Framily 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	
	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	Dedu App
Volik	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
lealth care provider's	Other practitioner office visit	\$15		\$20	
office or	·				
linic 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	
Denomination of	Tier 2	\$25		\$20	
Orugs to treat Uness or condition	Tier 3	\$40		\$30	
condition		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	
mmediate	medical transportation (molating emergency and non-emergency)	φ130		\$150	
attention	Urgent care	\$15		\$20	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	10% 10%		\$250 per day up to 5 days No charge	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
John	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
Help recovering or		·		\$150 per day up to	
other special	Skilled nursing care	10%		5 days	
learn 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 2024 Dental	
Services	Periodontal Maintenance Services	20 /0		Copay Schedule	
	Crowns and Casts				
Ohild Door	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2024 Dental	
Services	Prosthodontics			Copay Schedule	
Child					
	Medically necessary orthodontics	50%		\$1,000	
Child Orthodontics	Oral Surgery	50%		\$1,000	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - A'	V Calculator	<del>81.9%</del> 81.5	0/6	<del>81.5%</del> <u>81.6</u>	10%
uariai value - A	v Calculator Plan design includes a deductible?	81.9% 81.5 No	<u>70</u>	81.5% <u>81.6</u> No	<u>1%</u>
	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 / \$	
	Individual Out-of-pocket maximum			\$8,700	
	Family Out-of-pocket maximum			\$17,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's	Other practitioner office visit	\$35		\$35	
office or clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
				\$15	
Orugs to treat	Tier 2	\$60		\$60	
condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpotiont	Surgery facility fee (e.g., ASC)	30%		\$130	
Outpatient services	Physician/surgeon fees	30%		<del>\$40</del> <u>\$60</u>	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	<del>\$350</del> \$330		<del>\$350</del> \$330	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$35		\$35	
lospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%		\$330 \$350 per day up to 5 days	
	Physician/surgeon fee	30%		No charge	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
recovering or	Skilled nursing care	30%		\$150 per day up to	
other special nealth needs	•			5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Shild D.	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No obara-		No obara-	
and Preventive	Sealants per Tooth	No charge		No charge	
. cvenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See <del>2024</del> <u>2025</u>	
Basic Bervices	Periodontal Maintenance Services	20%		Dental Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental		500/		See <del>2024</del> 2025	
Major Services	Periodontics (other than maintenance)	50%		Dental Copay Schedule	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

#### 2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: July 20, 2023 April 18, 2024

· · · · · · · · · · · · · · · · · · ·	nefits and Coverage	CCSB-only		CCSB-only	
=	amounts describe the Enrollee's out of pocket costs.	Gold		Gold	
member dest enaie	anio di constito di la Entra con catto i postito cocce.	Coinsurance Pla	n	Copay Plan	
Actuarial Value - A\	/ Calculator	<del>78.8%</del> <u>79.1%</u>		80.7% <u>80.5%</u>	
/ totalina value / to	Plan design includes a deductible?		acv	Yes, Medical/Phari	
	Integrated Individual deductible	N/A	аоу	N/A	Пасу
	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	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$25	Дрисэ	\$35	Дрисэ
Health care	·····-, ······	<b>\$20</b>		ψου	
provider's	Other practitioner office visit	\$25		\$35	
office or clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55 \$55	
10313					V
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
	Tier 1	\$15		\$15	
Drugs to treat	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	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	20%	X	\$250	X
	Urgent care	\$25		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	20%	X X	\$600 per day up to 5 days	х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Halo	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
Help recovering or					
other special health needs	Skilled nursing care	20%	X	\$300 per day up to 5 days	X
nouth necus	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		See 2024 Dental Copay Schedule	
Services	Periodontal Maintenance Services  Crowns and Casts				
	Endodontics				
Child Dental		E00/		See 2024 Dental Copay	
Major Services	Periodontics (other than maintenance)	50%		Schedule	
	Prosthodontics				
Oh.iid	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

#### 2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: July 20, 2023 April 18, 2024

Summary	of Benefits and Cove	rage

<del>-</del>	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
4	/ Only date	74.00/ 74.00/	
ctuarial Value - A\		<del>71.8%</del> <u>71.6%</u>	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm	acy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / <del>\$150</del> \$50 /	\$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / <del>\$300</del> <u>\$100</u>	
	Individual Out-of-pocket maximum	<del>\$9,100</del> <u>\$8,700</u>	
	Family Out-of-pocket maximum	<del>\$18,200</del> <u>\$17,400</u>	!
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care provider's	Other practitioner office visit	\$50	
office or			
clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	<del>\$19</del> <u>\$18</u>	
D	Tier 2	\$60	Pharmacy
Drugs to treat illness or			deductible
condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy
		after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	30%	
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	<del>\$450</del> \$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$50	
Han State of a con-	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х
Hospital stay	Physician/surgeon fee	30%	
Mental	Mental/behavioral health and substance use disorder outpatient office		
health, behavioral	visits	\$50	
health, or	Mental/behavioral health and substance use disorder other outpatient		
substance abuse needs	items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Hala	Outpatient Rehabilitation and Habilitation services	\$50	
Help recovering or	·		Х
other special health needs	Skilled nursing care	30%	^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dantal	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	No onarge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	000/	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
wajoi	,		
Services	Prosthodontics		
-	Prosthodontics Oral Surgery		

Child Medically necessary orthodontics

2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB Date: July 20, 2023 April 18, 2024 CCSB-only Silver Coinsurance Plan CCSB-only Silver Copay Plan Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator <del>69.7%</del> <u>69.1%</u> <del>70%</del> <u>69.5%</u>

ctuariai value - A	V Calculator	<del>70%</del> <u>69.5%</u>		<del>69.7%</del> <u>69.1%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	пасу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0		\$2,500 / \$300 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$	
	· · · · · · · · · · · · · · · · · · ·				O .
	Individual Out-of-pocket maximum			\$8,750	
	Family Out-of-pocket maximum			\$17,500	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical	Service Type	Member Cost Share	Deductible	Member Cost Share	Deductible
Event			Applies		Applies
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care	Other practitioner office visit	\$55		\$55	
provider's office or	Other practitioner office visit	ψ00		φυσ	
clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
Tooto					
Tests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	Х	\$300	Х
	Tier 1	\$20		\$19	
			Pharmacy		Pharmacy
Drugs to treat	Tier 2	\$75	Pnarmacy deductible	\$85	deductible
illness or condition	Tier 3	\$105	Pharmacy	\$110	Pharmacy
CONTRICT	I NO. U	φιυσ	deductible	φιΙΟ	deductible
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharmacy
		pharmacy deductible	deductible	pharmacy deductible	deductible
0.4	Surgery facility fee (e.g., ASC)	35%	X	35%	Х
Outpatient services	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	X	35%	Х
			Λ		^
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	35%	Х	35%	X
attention					
	Urgent care	\$55		\$55	
	•			·	
	Eacility fee (e.g. bosnital room) for innatient stay (including labor and				
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	Χ	35%	Х
i iospitai stay	Physician/surgeon fee	35%	Х	35%	
Mental					
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55	
behavioral health, or					
substance	Mental/behavioral health and substance use disorder other outpatient	\$55		\$55	
abuse needs	items and services			,	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	35%		\$45	
Uala	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
Help recovering or		·		·	
other special	Skilled nursing care	35%	X	35%	X
health needs	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care				_	
ouro	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	Restorative Procedures			See 2024 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		Schedule Schedule	
OCI VICES					
	Crowns and Casts				
Child Dental	Endodontics			See 2004 D4-1 0	
Major	Periodontics (other than maintenance)	50%		See 2024 Dental Copay Schedule	
Services	Prosthodontics				
	Oral Surgery				
Child					
J11113	Medically necessary orthodontics	50%		\$1,000	

50%

\$1,000

#### 2024 2025 Patient-Centered Benefit Plan Designs

10.0 EHB Date: July 20, 2023 April 18, 2024 Summary of Benefits and Coverage CCSB-only Silver HDHP Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator <del>71.7%</del> <u>71.2%</u> Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2.850 integrated Integrated Family deductible \$5,700 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A \$7,500 Individual Out-of-pocket maximum Family Out-of-pocket maximum \$15,000 HSA plan: Self-only coverage deductible \$2,850 HSA family plan: Individual deductible See endnote Common Medical Service Type Member Cost Share Deductible Applie Event Primary care visit to treat an injury, illness, or condition 25% Health care provider's 25% Other practitioner office visit Х office or Specialist visit clinic visit 25% Preventive care/ screening/ immunization No charge Х Tests X-rays and Diagnostic Imaging Х Imaging (CT/PET scans, MRIs) 25% Х 25% up to \$250 per Tier 1 Х 25% up to \$250 per Tier 2 Х Drugs to treat script 25% up to \$250 per condition Tier 3 Х script 25% up to \$250 per Tier 4 script Surgery facility fee (e.g., ASC) 25% Х Outpatient services Physician/surgeon fees 25% Х Outpatient visit 25% Х Emergency room facility fee (waived if admitted) 25% Emergency room physician fee (waived if admitted) 0% Х Medical transportation (including emergency and non-emergency) Need 25% Х immediate Urgent care 25% Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Hospital stay Mental Mental/behavioral health and substance use disorder outpatient office 25% health. visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance abuse needs 25% Prenatal care and preconception visits No charge Pregnancy Home health care (cost share per visit) 25% Х Outpatient Rehabilitation and Habilitation services 25% Х Help recovering or Skilled nursing care 25% Х other special health needs Durable medical equipment 25% Х Eye exam No charge Child eye 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures 20% Services Periodontal Maintenance Services Crowns and Casts Endodontics **Child Dental** Major Services Periodontics (other than maintenance) 50% Prosthodontics Oral Surgery Medically necessary orthodontics 50%

#### 2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB

tuarial Value - AV	/ Calculator Plan design includes a deductible?	100%-150%		150%-200% FPL	
tuarial Value - AV					
	Plan design includes a deductible?	<del>94.9%</del> <u>94</u>	<u>.7%</u>	<del>87.9%</del> <u>88.0%</u>	
	r ian design molddes a deddelible:	Yes, Medical/F	Pharmacy	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$75</del> <u>\$0</u> / \$1		\$800 <u>\$1,400</u> / <del>\$50</del> <u>\$35</u>	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$150 <u>\$0</u> / \$		\$1,600 <u>\$2,800</u> / \$100 <u>\$7</u>	<u>'00</u> / \$0
	Individual Out-of-pocket maximum	\$1,150 <u>\$1</u>		\$3,150 <u>\$3,050</u>	
	Family Out-of-pocket maximum		<u>.,600</u>	<del>\$6,300</del> <u>\$6,100</u> N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
Event	Primary care visit to treat an injury, illness, or condition	\$5	уфрисс	\$15	7 (5)
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		<del>\$6</del> \$8	
Druge to the of	Tier 2	\$10		\$25	Pharm
Drugs to treat illness or		·			deduct Pharm
ondition	Tier 3	\$15		\$45	deduct
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharm deduct
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient	Physician/surgeon fees	10%		20%	
ervices	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	10% 10%	Х	20% 20%	X
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	20%	x
other special nealth needs			^		
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Bervices	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental		F00/		5007	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				

## 2024 2025 Patient-Centered Benefit Plan Designs 10.0 EHB

tuarial Value - AV Calculator  Plan design includes a deductible?  Integrated Individual deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible N/A  Common Medical  Plan design includes a deductible? N/A  N/A  Service Type  Plan design includes a deductible?  N/A  Service Type  Plan design includes a deductible?  N/A  Service Type  Plan design includes a deductible?  N/A  Service Type  Plan design includes a deductible  N/A  Service Type  Member Cost Share  Poductible  N/A  Deductible  Deductible  N/A  Deductible	ember Cost Share	amounts describe the Enrollee's out of pocket costs.	<b>Silver Plan</b> 200%-250% FPI	
Plan design includes a deducablist integrated involvated advantable integrated involvated advantable in the integrated involvated independent Fermity of possible individual deducables. Not integrated: Marciae / Pharmacy / Dental Sci., 400 / 1440 300 / 180 200 / 180			250% 250% 111	
Individual deductible, NOT integrated. Medical Planmy deductible Individual deductible, NOT integrated. Medical Planmy properties Family due-foperited maximum Family Due-foperited maximum Family Due-foperited maximum HSAs prizer facel properties of properties of the properties o	tuarial Value - A\			
Integrated Family deductible, NOT integrated. Modical / Pharmacy   Dental   Family deductible, NOT integrated. Modical remains   Family deductible, NOT   Fa		-		асу
Individual deductible, NOT integrated: Medical / Plammaray / Dental Salpo / \$10,001 Stable 2017 \$0 \$0,000 Stab				
Family addactable. NOT integrated Medical / Pharmacy / Domini   \$1,000 / \$200 / \$200   \$200				/ \$0
Hash plans. Self-only coverage deacticities HSA plans. Self-only coverage deacticities HSA tamp year. Individual deacticities HSA tamp year. Individual deacticities NA  Primary cate visit to bread an injury, times, or condition Offer practicionar office visit Seciolistic visit Preventive carea screening immunication Lineary visit Preventive carea screening immunication Lineary visit Preventive carea screening immunication Lineary visit Lineary vi				
MSA plans: Self-only coverage deductable   NA			· · · · · · · · · · · · · · · · · · ·	_
HSA family place: Individual deductible   Nice		Family Out-of-pocket maximum	<del>\$15,100</del> <u>\$14,70</u> 0	<u>)</u>
Primary care vaid to treat an injury, Illiness, or condition   Service Type		HSA plan: Self-only coverage deductible	N/A	
Medical providers and provider	0	HSA family plan: Individual deductible	N/A	
Medical transportation   Content of the services   Security   Se	Medical	Service Type	Member Cost Share	Deductib Applies
provider's Other practitioner office visit  Festil Visit  First 2  First 3  First 3  First 4  First 4  First 4  First 3  First 4  First 3  First 4  First 3  First 4  First 4  First 3  First 4  First 4  First 4  First 4  First 4  First 4  First 3  First 4  Fir		Primary care visit to treat an injury, illness, or condition	<del>\$50</del> <u>\$35</u>	
Clinic visit   Specialist   Special		Other practitioner office visit	<del>\$50</del> <u>\$35</u>	
Proventive care's screening immunication  Laboratory Tests  Laboratory Tests  X-ray and Diagnostic Imaging Imaging (CTIPPET caces, MRIs)  Tier 1  Tier 2  S55  Tier 1  Tier 2  S55  Tier 3  Suppey facility fee (e.g., ASC) Physician'surgeon fees Outpatient Services  Outpatient Services  Need immediate Intention  No charge  Facility fee (e.g., ASC) Physician'surgeon fees Outpatient tention  Urgent care  Facility fee (e.g., ASC) Physician'surgeon fees Outpatient tention  No charge  Facility fee (e.g., ASC) Physician'surgeon fees Outpatient tention  Urgent care  Facility fee (e.g., ASC) Physician'surgeon fees Outpatient tention  Urgent care  Facility fee (e.g., ASC) Physician'surgeon fees Outpatient tention  Wedical transportation (encluding emergency and non-emergency)  S250  Wedical transportation (encluding emergency and non-emergency)  Urgent care  Facility fee (e.g., hospital room) for ispatient stay (including labor and diview), mental health, and substance use disorder outpatient office vites  Wentall-behavioral health and substance use disorder outpatient office vites  Wentall-behavioral health and substance use disorder outpatient office vites  Wentall-behavioral health and substance use disorder outpatient office vites  Wentall-behavioral health and substance use disorder outpatient office vites  Wentall-behavioral health and substance use disorder outpatient office vites  S40 S35  Wentall-behavioral health and substance use disorder outpatient office vites  Wentall-behavioral health and substance use disorder outpatient office vites  S40 S35  Wentall-behavioral health and substance use disorder outpatient office vites  S40 S35  Wentall-behavioral health and substance use disorder outpatient office vites  S40 S35  Wentall-behavioral health and substance use disorder outpatient office vites  S40 S35  Wentall-behavioral health and substance use disorder outpatient office vites  S40 S35  Wentall-behavioral health and substance use disorder outpatient office vites  S40 S35  Wentall-behavioral health and substan		Specialist visit	\$00 \$85	
Laboratory Tests  X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)  Ter 1  Ter 2  Ter 3  Ter 2  Ter 3  Ter 4  Surgery facility fee (e.g., ASC) Physician/surgeno fees Outpatient visit  Emergency room facility fee (walved if admitted) Emergency room physicion fee (walved if admitted) Urgent care  Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, meriato health, and substance use) Fylysician/surgeno fee  Wental behavioral health and substance use disorder outpatient office visits  Wental behavioral health and substance use disorder outpatient dema and services  Pregnancy  Prematic care and precorception visits Home health care (cost share per visit) Outpatient Terhabilitation and Healthation services  Pregnancy  Prematic care and precorception visits Home health care (cost share per visit) Outpatient Resolution and Healthation services  Skilled nursing care Outpatient Resolution Durable medical equipment Hospice service  Preventive - V.ray Sealants per Tooth Topical Floride Application Space Merinalmens - Fixed  Child Dental Basic Services Child Dental Basic Servi	Cillic Visit	· ·	<del></del>	
Tests   X-rays and Diagnostic Imaging   \$95   \$325   \$325		-		
Imaging (CT/PET scans, MRIs)  Tier 1  Tier 2  SS5  Tier 1  Tier 2  SS5  Tier 3  Tier 4  Surgery facility fee (e.g., ASC)  Outpatient visit  Emergency room facility fee (waived if admitted)  Emergency room facility fee (waived if admitted)  Emergency room physician fee (waived if admitted)  Emergency room physician fee (waived if admitted)  Emergency room physician fee (waived if admitted)  Medical transportation (including emergency and non-emergency)  Urgent care  SS0 335  Hospital stay  Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee  Mental health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient and substance used sorder other outpat	Tanta	•		
Tier 1 Tier 2 Tier 3 Tier 4 Tier 3 Tier 4  Surgery facility fee (e.g., ASC) Physician/kurgen fees Outpatient visit Emergency room facility fee (waived if admitted) Urgent care  Pacility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/kurgen fee Physician/kurgen fee Phothadional delivery, mental health and substance use disorder outpatient office visits Phothadional transportation of the patient stay (including labor and delivery, mental health, and substance use) Physician/kurgen fee Physician/kurgen fee Physician/kurgen fee Phothadional transportation (including emergency) Physician/kurgen fee Physician/kurgen fee Phothadional transportation (including emergency and non-emergency)  Wental health, and substance use disorder outpatient office visits Phothadional transportation (including emergency and non-emergency)  Wental health and substance use disorder outpatient office visits Phothadional transportation (including emergency and non-emergency)  Wental health and substance use disorder outpatient office visits Phothadional transportation (including labor and substance use) Physician/kurgen fee Physician/kurgen fee Phothadional transportation (including emergency)  Wental health and substance use disorder outpatient office visits Phothadional transportation of the physician fee (waived if admitted)  Wental health and substance use disorder outpatient office visits Phothadional transportation of the physician fee (waived if admitted)  Wental health and substance use disorder outpatient office visits Phothadional transportation of the physician fee (waived if admitted)  Wental health and substance use disorder outpatient office visits Phothadional transportation of the physician fee (waived if admitted)  Wental health and substance use of social substance use of social substance use of social subs	rests			
Drugs to treat Illinoss or Tier 2 Tier 3 Tier 4 Stage y facility foe (e.g., ASC) Physician/surgeon fees Outpatient services Outpatient visit Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room facility fee (waived if admitted) Medical transportation (including emergency and non-emergency)  Urgent care  Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mertal health, and substance use) Physician/surgeon fee  Wental health, or you health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient lems and services  Pregnancy Prevaltal care and preconception visits Non charge  Hone health care (cost share per visit) Quagient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service  Child outside of Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Preventive - Cleaning Preventive - Scalars Preventive - Cleaning Prevent		Imaging (CT/PET scans, MRIs)	\$325	
Drugs to treat lines so rondition  Tier 3  Tier 4  Tier 4  Tier 4  Tier 3  Tier 4  Tier 3  Tier 4  Tier 4  Tier 4  Tier 4  Tier 4  Tier 3  Tier 4  Tie		Tier 1	<del>\$19</del> <u>\$20</u>	
Tiler 3 Ter 4 Ter 5 S85 Cover place of the condition Ter 5 Ter 4 Ter 4 Ter 4 Ter 4 Ter 5 Suggery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Medical transportation (including emergency and non-emergency) Terret are Terret	Druge to troat	Tier 2	\$55	
Tier 4 20% up to \$250 per script after pharmacy deductible and face pharmacy deductible and phase services are also as a commendate attention and phase are also as a commendate attention	_			
Durpatient services  Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit  Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge  Emergency room physician fee (waived if admitted)  Urgent care  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgen fee  Mentall behavioral health and substance use disorder outpatient office visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder other outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and substance use disorder outpatient diffice visits Dehavioral health and	condition	Tier 3	\$85	
Dutpatient services Outpatient visit  Revives Outpatient visit  Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge  Medical transportation (including emergency and non-emergency)  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee  Mental delivery, mental health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient terms and services  Pregnancy  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Aud  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Durable medical equipment Hospice service  Child Dental Diagnostic and Preventive - Cleaning Preventive - Cleaning Preventive - V-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Services  Periodontics  Child Dental Major Services  Periodontics (other than maintenance) Prosthodorotics Oral Surgery		Tier 4		
President surgeon tees Outpatient visit  Emergency room playiscian fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge Medical transportation (including emergency and non-emergency)  Emergency room physician fee (waived if admitted) No charge  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Hospital stay  Mental/behavioral health and substance use disorder outpatient office visits Wental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient items and services  Mental/behavioral health and substance use disorder outpatient items and services  Pregnancy  Prenatal care and preconception visits No charge  Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Outpatient Rehabilitation and Habilitation services  No charge  Child Opental Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services  Periodontal Maintenance Services  Periodontal Maintenance Services  Periodontics Oral Surgery  Prosthodontics Oral Surgery		Surgery facility fee (e.g., ASC)	30%	
Outpatient visit  Emergency room facility fee (waived if admitted)  Emergency room physician fee (waived if admitted)  Emergency room physician fee (waived if admitted)  Medical transportation (including emergency and non-emergency)  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Hospital stay  Hospital stay  Mental/health, or behavioral health and substance use disorder outpatient office visits  behavioral health, or behavioral health and substance use disorder other outpatient items and services  Pregnancy  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Child Dental Dental Diagnostric and Preventive - Cleaning  Pre	_	Physician/surgeon fees	30%	
Emergency room physician fee (waived if admitted)  No charge  Hospital stay  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee  Mental health, behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  No charge  Prevactives and services  Skilled nursing care outpatient office visits  No charge  No charge  No charge  No charge  Preventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental Basic  Services  Crowns and Casts  Endodontics  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Prosthodontics  Oral Surgery		Outpatient visit	30%	
Medical transportation (including emergency and non-emergency)  S250  Wedical transportation (including emergency and non-emergency)  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee  Mental delivery, mental health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient items and services  Pregnancy  Prenatal care and preconception visits  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Child eye  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Child Dental Diagnostic and Preventive - Cleaning  Preventi		Emergency room facility fee (waived if admitted)	<del>\$450</del> \$350	
Medical transportation (including emergency and non-emergency)  We distributed transportation (including emergency and non-emergency)  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee  Mental health, or with the substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Pregnancy  Prenancy  Prenancy Prenancy Prenancy Prenancy Prenancy  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Our pushelm Rehabilitation and Habilitation services  Skilled nursing care  Our pushelm Rehabilitation and Habilitation services  Skilled nursing care  Our pushelm Rehabilitation and Habilitation services  No charge  Preventive  Child eye Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - Cleaning  Preventive - Scalants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental Basic  Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery		Emergency room physician fee (waived if admitted)	No charge	
Immediate attention  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, merital health, and substance use) Physician/surgeon fee  Mental health, or substance delivery, merital health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Seo \$335  Mental/behavioral health and substance use disorder outpatient office visits  No charge  Durable medical equipment  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Oral Exam  Preventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental  Basic  Child Dental  Basic  Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery	Need	, , , , ,	-	
Urgent care  Urgent care  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, merital health, and substance use)  Physician/surgeon fee  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient office visits  Montal/behavioral health and substance use disorder other outpatient office visits  Montal/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Montal/behavioral health and substance use disorder outpatient office visits  Montal/behavioral health and substance use disorder outpatient office visits  Montal/behavioral health and substance use disorder outpatient office visits  No charge  Help recovering or outpatient office visits  No charge  Skilled nursing care  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Jurable medical equipment  Hospice service  No charge  No charge  Oral Exam  Preventive - Cleaning  No charge  No charge  Child Dental  Basic  Scrvices  Crowns and Casts  Endodontics  Prosthodontics  Oral Surgery	immediate	model and portation (modeling emergency and non-emergency)	Ψ230	
Hospital stay Home health and substance use disorder outpatient office visits Hospital stay Home health and substance use disorder other outpatient items and services Hospital stay Home health care (cost share per visit) Home health care (cost share per visit) Houp Hospital stay Home health care (cost share per visit) Houp Hospital stay Home health care (cost share per visit) Houp Hospital stay Home health care (cost share per visit) Houp Hospital stay Home health care (cost share per visit) Houp Hospital stay Home health care (cost share per visit) Houp Home health care (cost share per visit) Houp Home health care (cost share per visit)  Uutpatient Rehabilitation and Habilitation services  Skilled nursing care  No charge  No charge  No charge  Child Dental Diagnostic And Preventive - Cleaning Preventive - Cray  Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services  Crowns and Casts Endodontics Prosthodontics Oral Surgery	attention	Lizant eare	<b>ሲ</b> ደር	
delivery, mental health, and substance use) Physician/surgeon fee  Mental health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient items and services  Pregnancy Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Skilled nursing care Ourable medical equipment Hospice service No charge  Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery		orgeni care	<del>900</del> <del>202</del>	
Physician/surgeon fee 30%  Mental health, beatth, or substance abuse needs  Pregnancy  Pregnancy  Prenatal care and preconception visits  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care Durable medical equipment Hospice service  Child Dental Diagnostic and Preventive  Child Dental Preventive  Child Dental Basic Services  Crowns and Casts  Endodontics  Child Dental Maintenance Services  Child Dental Basic Services  Child Dental Maintenance Services  Child Dental Major			30%	Х
health, beath, behavioral health, visits  Mental/behavioral health and substance use disorder other outpatient litems and services  Mental/behavioral health and substance use disorder other outpatient litems and services  Pregnancy  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Cutpatient Rehabilitation and Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Child Dental Diagnostic and Preventive - Cleaning  Preventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental Basic  Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery	Hospital stay		30%	
behavioral nealth, or substance abuse needs  Pregnancy  Pregnancy  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Child Dental Maintenance Services  Child Dental Major Services  Child Dental Major Services  Child Dental Major Services  Child Dental Major Services  Periodontal Maintenance Services  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery		Mental/behavioral health and substance use disorder outpatient office		
health, or substance abuses needs buses needs with and substance use disorder other outpatient items and services  Pregnancy  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Durable medical equipment  Hospice service  Child eye care  1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental Basic Services  Child Dental Maintenance Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery		'	<del>\$50</del>	
Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service No charge  Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge  Oral Exam Preventive - Cleaning Preventive - Array Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Child Dental Major Services Child Dental Preventive Child Dental Major Services Child Dental Preventive Child Dental Preventi	health, or		<del>\$50</del> \$35	
Help recovering or other special health needs  Skilled nursing care Durable medical equipment Hospice service  Child eye care 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  Child Dental Basic Services  Child Dental Basic Services  Child Dental Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery				
Help recovering or other special health needs  Skilled nursing care Durable medical equipment Hospice service  Child eye care  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam Preventive - Cleaning Preventive - A-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Bervices  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  Outpatient Rehabilitation and Habilitation services Skilled nursing care 30% X X X X X X X X X X X X X X X X X X X	. ognancy	· · ·	-	
Skilled nursing care other special health needs  Skilled nursing care Durable medical equipment Hospice service No charge  Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  Skilled nursing care 30% X  X  X  Au  Au  Au  Au  Au  Au  Au  Au				
other special health needs  Durable medical equipment  Hospice service  Child eye care  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - Aray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental Basic Services  Crowns and Casts  Endodontics  Prosthodontics  Oral Surgery  Skilled nursing care  30%  X  X  Analy  20%  No charge  No charge  No charge  Analy  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental Basic Services  Periodontal Maintenance Services  Child Dental Major Services  Child Dental Major Services  Prosthodontics  Oral Surgery	•	·	<del></del>	
Hospice service	other special	Skilled nursing care	30%	X
Child eye care  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  Child Dental Basic Services  Periodontal Maintenance Services  Child Dental Major Services  Child Dental Major Services  Prosthodontics Prosthodontics Oral Surgery  No charge	пеанп пееds	Durable medical equipment	20%	
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  Child Dental Basic Services  Child Dental Maintenance Services  Child Dental Major Services  Child Dental Major Services  Periodontics (other than maintenance) Prosthodontics Oral Surgery  No charge		Hospice service	No charge	
Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Child Dental Maintenance Services  Child Dental Major Services Child Dental Major Services Oral Surgery  No charge	Child eye	Eye exam	No charge	
Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery	care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  No charge No charge  No charge  No charge  No charge  No charge  No charge  No charge  No charge  No charge  No charge  No charge  No charge		Oral Exam		
Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  No charge  No charge  No charge  No charge  No charge  No charge		Preventive - Cleaning		
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Periodontal Maintenance Services Child Dental Endodontics Periodontics (other than maintenance) Services  Prosthodontics Oral Surgery		Preventive - X-ray		
Topical Fluoride Application Space Maintainers - Fixed  Restorative Procedures Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	and	Sealants per Tooth	No charge	
Child Dental Basic Services Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Periodontics Oral Surgery  20%  20%  50%  50%  50%  50%	rieventive	Topical Fluoride Application		
Child Dental Basic Services Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Periodontics Oral Surgery  20%  20%  50%  50%  50%  50%		Space Maintainers - Fixed		
Basic Services Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Child Dental	·		
Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery			20%	
Child Dental Major Periodontics (other than maintenance) 50% Services Prosthodontics Oral Surgery	OEI VICES			
Child Dental Major Periodontics (other than maintenance) 50%  Services Prosthodontics  Oral Surgery				
Services Prosthodontics Oral Surgery				
Prosthodontics Oral Surgery	•	,	50%	
		Oral Surgery		

Summary	of Renefits	and Co	overage

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plai	n
uorial Valenta	/ Calculator	04.40/.00.00/		04.00/	
uarial Value - A\		<del>64.4%</del> <u>63.6%</u>		64.9%	
	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integrat	
	Integrated Individual deductible	N/A		\$7,050 <u>\$6,650</u> int	-
	Integrated Family deductible	N/A	450 / 60	\$14,100 <u>\$13,300</u> ir	ntegrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 <u>\$5,800</u> / \$500 <u>\$</u>		N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$12,600 <u>\$11,600</u> / <del>\$1,000</del> \$ <del>9,100</del> \$8,850	_	N/A <del>\$7,050</del> \$6,6	50
	Individual Out-of-pocket maximum	\$ <del>18,200</del> \$17,70		<del>\$1,000</del> \$0,0	
	Family Out-of-pocket maximum  HSA plan: Self-only coverage deductible	<del>φτο,200</del> φτ <i>τ</i> ,70	0	<del>\$7,050</del> \$6,6	
	HSA family plan: Individual deductible	N/A		\$7,050 \$6,6	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc
vent	Primary care visit to treat an injury, illness, or condition	\$60	After 1st three non-	0%	Appl
ealth care	Other practitioner office visit	\$60	After 1st three non-	0%	×
ffice or	·		preventive visits  After 1st three non-		
linic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	×
ests	X-rays and Diagnostic Imaging	40%	x	0%	×
	Imaging (CT/PET scans, MRIs)	40%	x	0%	>
	Tier 1	<del>\$17</del> \$19	Pharmacy Deductible	0%	>
	IIOI I		,	U%	, ×
rugs to treat	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	×
ness or ondition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	×
J. IUI II	5	pharmacy deductible	Deductible	U /0	′
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	>
	Surgery facility fee (e.g., ASC)	40%	x	0%	>
utpatient	Physician/surgeon fees	40%	x	0%	<b>\</b>
ervices	Outpatient visit	40%	×	0%	, ,
	Emergency room facility fee (waived if admitted)	40%	X	0%	, }
			_ ^		
	Emergency room physician fee (waived if admitted)	No charge		0%	×
eed nmediate	Medical transportation (including emergency and non-emergency)	40%	X	0%	>
ttention	Urgent care	\$60	After 1st three non- preventive visits	0%	×
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	X	0%	X
ospital stay	delivery, mental health, and substance use) Physician/surgeon fee	40%	X	0%	×
lental ealth, ehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	>
ealth, or ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	×
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	>
elp	Outpatient Rehabilitation and Habilitation services	\$60		0%	×
ecovering or	Skilled nursing care	40%	X	0%	, ,
ther special ealth needs	-				
	Durable medical equipment	40%	X	0%	>
	Hospice service	No charge		0%	>
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				
	Preventive - Cleaning				
hild Dental iagnostic	Preventive - X-ray				
nd	Sealants per Tooth	No charge		No charge	
reventive	Topical Fluoride Application				
hild Day to	Space Maintainers - Fixed				
hild Dental asic	Restorative Procedures	20%		20%	
ervices	Periodontal Maintenance Services				
	Crowns and Casts				
hild Dental	Endodontics				
lajor	Periodontics (other than maintenance)	50%		50%	
ervices	Prosthodontics				
	Oral Surgery				

Summary	of Benefits and Cov	erage

=	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A'	V Calculator		
Actuariai value - A	V Calculator Plan design includes a deductible?	Vec	integrated
	Integrated Individual deductible		1,200 integrated
	Integrated Family deductible		8,400 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	<del>\$9,4</del>	<del>50</del> <u>\$9,200</u>
	Family Out-of-pocket maximum	<del>\$18,9</del>	<del>00</del> <u>\$18,400</u>
	HSA plan: Self-only coverage deductible		N/A
Common	HSA family plan: Individual deductible		N/A
Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three non- preventive visits
office or clinic visit	Specialist visit	0%	×
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	×
	Tier 1	0%	X
Drugs to treat illness or	Tier 2	0%	X
condition	Tier 3	0%	Х
	Tier 4	0%	х
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient	Physician/surgeon fees	0%	x
services	Outpatient visit	0%	x
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	0%	x
immediate attention		070	^
attention	Urgent care	0%	After 1st three non-
			preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	x
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	0%	X
Mental		070	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
health, or	Mental/behavioral health and substance use disorder other outpatient		
substance abuse needs	items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	x
Help	Outpatient Rehabilitation and Habilitation services	0%	x
recovering or	Skilled nursing care	0%	x
other special health needs	Durable medical equipment	0%	X
	Hospice service	0%	×
Child ave	Eye exam	No charge	•
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	0%	x
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	0%	Х
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	0%	×
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	0%	Х
Orthodontics	,,	0,0	Λ,

ember Cost Share a	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 94 Plan 100%-150% FPL		CA Enh CSR Silver 87 Plan 150%-200% FPL		
tuarial Value - A\	/ Calculator	<del>94.7%</del> <u>95</u>	104	<del>88.8%</del> <u>88.9%</u>		
tuariai value - Av	Plan design includes a deductible?	No	<u>. 1 70</u>	No		
	Integrated Individual deductible	N/A		N/A		
	Integrated Family deductible	N/A		N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0		
	Individual Out–of–pocket maximum	\$1,150	)	\$3,000		
	Family Out-of-pocket maximum		)	\$6,000		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applie	
Event	Primary care visit to treat an injury, illness, or condition	\$5		\$15		
Health care	Other practitioner office visit	\$5		\$15		
provider's office or	Other practitioner office visit	Ψ3		Ψισ		
linic 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		
Orugs to treat	Tier 2	\$10		\$25		
Ilness or condition	Tier 3	\$15		\$45		
		10% up to \$150 per				
	Tier 4	script		15% up to \$150 per script		
	Surgery facility fee (e.g., ASC)	10%		20%		
Outpatient services	Physician/surgeon fees	10%		20%		
	Outpatient visit	10%		20%		
	Emergency room facility fee (waived if admitted)	\$50		\$150		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75		
immediate attention						
	Urgent care	\$5		\$15		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%		
Hospital stay	Physician/surgeon fee	10%		20%		
Mental	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15		
nealth, behavioral	visits	φ5		φισ		
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15		
abuse needs		No shares		No shares		
Pregnancy	Prenatal care and preconception visits  Home health care (cost share per visit)	No charge		No charge		
	Home health care (cost share per visit)	\$3		\$15		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15		
other special	Skilled nursing care	10%		20%		
nealth needs	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
01.11.7.	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray	No ob		No ob		
and Preventive	Sealants per Tooth	No charge		No charge		
· OTSINIVE	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures	2021		222		
Basic Services	Periodontal Maintenance Services	20%		20%		
	Crowns and Casts					
	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		50%		
Services	Prosthodontics					
	Oral Surgery					

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 7 Above 200% FPI	
tuarial Value - A\	/ Calculator	<del>79.5%</del> 79.2%	
tuariai value - Av	V Calculator  Plan design includes a deductible?	<del>79.5%</del> <u>79.2%</u> No	
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$6,100	
	Family Out-of-pocket maximum	\$12,200	
	HSA family plan; Individual deductible	N/A N/A	
Common	HSA family plan: Individual deductible	N/A	Deducti
Medical Event	Service Type	Member Cost Share	Applie
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
D 4- 44	Tier 2	\$55	
Drugs to treat illness or condition	Tier 3	\$85	
Condition			
	Tier 4	20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	30%	
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	30%	
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35	
behavioral	visits	,	
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	
	Home health care (cost share per visit)	\$40	
Ualm	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or			
other special health needs	Skilled nursing care	30%	
	Durable medical equipment	20%	
	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	No charge	
and Preventive	Sealants per Tooth	-	
	Topical Fluoride Application		
a	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
Sel vices	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	





mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
tuarial Value - A\	/ Calculator	91.9%		<del>90.7%</del> <u>91.6</u>	<u>i%</u>
	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	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$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	Deduc Appli
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
lealth care provider's	Other practitioner office visit	\$15		\$15	
office or	Considirate de la	***		400	
linic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$7		\$7	
rugs to treat	Tier 2	\$16		\$16	
Iness or ondition	Tier 3	\$25		\$25	
onunion	161 0				
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient ervices	Physician/surgeon fees	10%		\$20	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed	Medical transportation (including emergency and non-emergency)	_		_	
mmediate	medical transportation (including emergency and non-emergency)	\$150		\$150	
ttention	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$225 per day up to	
lospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental lealth, lehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
ealth, or substance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
1-1-	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
lelp ecovering or		·		\$125 per day up to	
ther special	Skilled nursing care	10%		5 days	
ealth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	Ū		Ü	
	Preventive - Cleaning				
Child Dental					
Diagnostic nd	Preventive - X-ray	Not Covered		Not Covered	
reventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
child Dental	Restorative Procedures	Not Covered		Not Covered	
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental		Not Covered		Not Covered	
Major Services	Periodontics (other than maintenance)	INOL Covered		NOT Coveted	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

ummary of Ber	-2023 April 18, 2024 nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	Ī	CCSB-onl Platinum Copay Pla	í
ctuarial Value - A\	√ Calculator	<del>91.2%</del> <u>91.3</u>	%	<del>89.4%</del> <u>90.5</u>	5%
	Plan design includes a deductible?	No		No	_
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$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		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	•	\$15		\$20	
Tests	Laboratory Tests				
16313	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat illness or	Tier 2	\$25		\$20	
condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$100	
	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		·		\$20	
	Urgent care	\$15		·	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	10% 10%		\$250 per day up to 5 days No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or		·		\$150 per day up to	
other special health needs	Skilled nursing care	10%		5 days	
	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		Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	Not Covered		Not Govered	
	Crowns and Casts				
Obild D	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - Δ'	V Calculator	<del>81.9%</del> <u>81.5</u>	0/4	<del>81.5%</del> <u>81.6</u>	10/2
tuariai value - A	Plan design includes a deductible?	No	<u>70</u>	No	170
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)		0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$8,700		\$8,700	
	Family Out-of-pocket maximum	\$17,400		\$17,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
provider's	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15		\$15	
	Tier 2				
Drugs to treat					
condition	Her 3			·	
	Tier 4	script		20% up to \$250 per script	
Outpationt	Surgery facility fee (e.g., ASC)	30%		\$130	
services	Physician/surgeon fees	30%		<del>\$40</del> <u>\$60</u>	
	Outpatient visit	20%		20%	
Need immediate	Emergency room facility fee (waived if admitted)	<del>\$350</del> \$330		<del>\$350</del> \$330	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$35		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	30%		\$330 \$350 per day up to 5 days	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35		\$0 \$0 \$0 / \$0 / \$0 \$0 / \$0 / \$0 \$0 / \$0 /	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$35		\$35	
abuse needs					
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
dedical event  dealth care provider's ffice or linic visit  dests  dests	Skilled nursing care	30%			
	Durable medical equipment	20%		· .	
	Hospice service	No charge		No charge	
Child ove	Eye exam	No charge		_	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)				
	Oral Exam			590	
Child Dental	·				
Diagnostic and	•	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
Ohili D	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	HSA plan: Self-only coverage deductable HSA family plan: Individual deductable PSA Family P				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
Jei vices	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

#### 2024 2025 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: July 20, 2023 April 18, 2024

Summary of Ber	refits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		CCSB-only Gold	
	<u> </u>	Coinsurance Pla	п	Copay Plan	
Actuarial Value - A\		<del>78.8%</del> <u>79.1%</u>		<del>80.7%</del> <u>80.5%</u>	
	Plan design includes a deductible?		acy	Yes, Medical/Pharr	macy
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		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	
Health care provider's	Other practitioner office visit	\$25		\$35	
office or clinic visit	Specialist visit	\$50		\$55	
Cillic visit		·		·	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	\$25 \$65		\$35 \$55	
10010	Imaging (CT/PET scans, MRIs)	20%		\$250	x
				·	*
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$40	
illness or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
					V
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$300	Х
services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%	.,	20%	.,
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	20%	X	\$250	X
	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
Mental	Physician/surgeon fee	20%	X	No charge	
health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
recovering or other special	Skilled nursing care	20%	x	\$300 per day up to 5 days	x
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	N-4 O		N-LO.	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
i i eventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	No. 1 O		N. C	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
Child D	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

ember Cost Share	efits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
ctuarial Value - A\		<del>71.8%</del> <u>71.6%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible Integrated Family deductible	N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / <del>\$150</del> \$50 /	\$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / <del>\$300</del> <u>\$100</u>	/ \$0
	Individual Out-of-pocket maximum	\$ <del>9,100</del> <u>\$8,700</u>	
	Family Out-of-pocket maximum	<del>\$18,200</del> <u>\$17,400</u>	<u>l</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical	Service Type	Member Cost Share	Deducti
Event	Primary care visit to treat an injury, illness, or condition	\$50	Applie
Health care provider's	Other practitioner office visit	\$50	
office or clinic visit	·		
CHINC VISIT	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	\$50 \$95	
Tesis	Imaging (CT/PET scans, MRIs)		
		\$325	
	Tier 1	<del>\$19</del>	
Drugs to treat	Tier 2	\$60	Pharma deducti
condition	Tier 3	\$90	Pharma deducti
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deducti
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	<del>\$450</del> \$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х
Hospital stay	Physician/surgeon fee	30%	
Mental	Mental/behavioral health and substance use disorder outpatient office		
health, behavioral health, or	visits	\$50	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other special	Skilled nursing care	30%	x
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	,101 0010104	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	1,51 0010160	
	Crowns and Casts		

Periodontics (other than maintenance)

Medically necessary orthodontics

Crowns and Casts Endodontics

Prosthodontics Oral Surgery

Child Dental Major Services

Not Covered

Not Covered

2024 2025 Patient-Centered Benefit Plan Designs 9.5 EHB Date: July 20, 2023 April 18, 2024 Summary of Benefits and Coverage CCSB-only CCSB-only Silver Coinsurance Plan Member Cost Share amounts describe the Enrollee's out of pocket costs Copay Plan Actuarial Value - AV Calculator <del>70%</del> <u>69.5%</u> <del>69.7%</del> <u>69.1%</u> Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy Integrated Individual deductible N/A N/A Integrated Family deductible N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$2,500 / \$300 / \$0 \$2,500 / \$300 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$5,000 / \$600 / \$0 \$5.000 / \$600 / \$0 Individual Out-of-pocket maximum \$8,600 \$8,750 Family Out-of-pocket maximum \$17.200 \$17,500 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Medical Service Type **Member Cost Share Member Cost Share** Event Primary care visit to treat an injury, illness, or condition \$55 \$55 Health care Other practitioner office visit \$55 \$55 provider's office or Specialist visit clinic visit \$90 \$90 Preventive care/ screening/ immunization No charge No charge \$55 Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) 35% Х \$300 Tier 1 \$19 \$20 Pharmacy Pharmacy Tier 2 \$75 \$85 Drugs to treat deductible deductible Pharmacy Pharmacv condition Tier 3 \$105 \$110 deductible deductible Pharmacy Pharmacy 30% up to \$250 per script afte 30% up to \$250 per script after Tier 4 pharmacy deductible pharmacy deductible deductible deductible Surgery facility fee (e.g., ASC) 35% 35% Х Х Outpatient Physician/surgeon fees 35% 35% Outpatient visit 35% 35% Emergency room facility fee (waived if admitted) 35% 35% Emergency room physician fee (waived if admitted) No charge No charge Need Medical transportation (including emergency and non-emergency) 35% Х 35% Х immediate \$55 Urgent care \$55 Facility fee (e.g. hospital room) for inpatient stay (including labor and 35% Х delivery, mental health, and substance use) Hospital stay Mental Mental/behavioral health and substance use disorder outpatient office health, behavioral health, or \$55 \$55 visits Mental/behavioral health and substance use disorder other outpatient substance \$55 \$55 abuse needs No charge Pregnancy No charge Home health care (cost share per visit) 35% \$45 Outpatient Rehabilitation and Habilitation services \$55 \$55 Help recovering or Skilled nursing care 35% 35% Х other special health needs Durable medical equipment 35% Hospice service No charge No charge Eye exam No charge No charge Child eye 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic Not Covered Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed **Child Dental** Not Covered Not Covered 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

Oral Surgery

Medically necessary orthodontics

2024 2025 Patient-Centered Benefit Plan Designs 9.5 EHB Date: July 20, 2023 April 18, 2024 CCSB-only Summary of Benefits and Coverage Silver HDHP Plan Member Cost Share amounts describe the Enrollee's out of pocket costs Actuarial Value - AV Calculator <del>71.7%</del> <u>71.2%</u> Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$2.850 integrated Integrated Family deductible \$5,700 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A \$7,500 Individual Out-of-pocket maximum Family Out-of-pocket maximum \$15,000 HSA plan: Self-only coverage deductible \$2,850 HSA family plan: Individual deductible See endnote Common Medical Service Type Member Cost Share Deductible Applie Event Primary care visit to treat an injury, illness, or condition 25% Health care provider's 25% Other practitioner office visit Х office or Specialist visit clinic visit 25% Preventive care/ screening/ immunization No charge 25% Tests X-rays and Diagnostic Imaging Х Imaging (CT/PET scans, MRIs) 25% Х 25% up to \$250 per Tier 1 Х 25% up to \$250 per Tier 2 Х Drugs to treat script 25% up to \$250 per condition Tier 3 Х script 25% up to \$250 per Tier 4 script Surgery facility fee (e.g., ASC) 25% Х Outpatient Physician/surgeon fees 25% Х Outpatient visit 25% Х Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) 0% Х Medical transportation (including emergency and non-emergency) Need 25% Х immediate Urgent care 25% Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Hospital stay Mental Mental/behavioral health and substance use disorder outpatient office 25% health. visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient items and services substance abuse needs 25% Prenatal care and preconception visits No charge Pregnancy Home health care (cost share per visit) 25% Х Outpatient Rehabilitation and Habilitation services 25% Х Help recovering or Skilled nursing care 25% Х other special health needs Durable medical equipment 25% Х Eye exam No charge Child eye 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 Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Services Periodontal Maintenance Services Crowns and Casts Endodontics **Child Dental** Major Services Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery

Medically necessary orthodontics

Not Covered

#### 2024 2025 Patient-Centered Benefit Plan Designs 9.5 EHB

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPL	
tuarial Value - A\	/ Calculator Plan design includes a deductible?	94.9% <u>94</u> Yes, Medical/F		87.9% 88.0% Yes, Medical/Pharm	2004
	Integrated Individual deductible	res, Medical/F	паппасу	Yes, Medical/Priam	lacy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$75</del> <u>\$0</u> / \$	0 / \$0	\$800 <u>\$1,400</u> / <del>\$50</del> <u>\$35</u>	<u>50</u> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	<del>\$150</del> <u>\$0</u> / \$		\$1,600 <u>2,800</u> / \$100 <u>\$7</u>	<u>'00</u> / \$0
	Individual Out-of-pocket maximum	\$1,150 <u>\$1</u>		\$3,150 <u>\$3,050</u>	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	<del>\$2,300</del> <u>\$2</u> N/A	<u>4,600</u>	\$ <del>6,300</del> \$ <u>6,100</u> N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$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		\$6 \$8	
					Pharma
Orugs to treat	Tier 2	\$10		\$25	deduct
condition	Tier 3	\$15		\$45	Pharm deduct
	Tier 4	10% up to \$150 per		15% up to \$150 per script	Pharm deduct
	Surgery facility fee (e.g., ASC)	script		20%	deduct
Outpatient	Physician/surgeon fees	10%		20%	
services	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention		,			
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%	Х	20%	X
Hospital stay	Physician/surgeon fee	10%		20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral health, or	visits				
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or	Skilled nursing care	10%	X	20%	x
other special health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	-			
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray			N. Co.	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
. 76vendve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	Not Covered		NOT COVERED	
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
Get vices	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	<b>Silver Plan</b> 200%-250% FPI	_
uarial Value - A\	/ Calculator	<del>74.0%</del> <u>73.9%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / <del>\$150</del> <u>\$350</u>	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / <del>\$300</del> <u>\$700</u>	7 \$0
	Individual Out-of-pocket maximum	\$7,550 <u>\$7,350</u>	
	Family Out-of-pocket maximum	<del>\$15,100</del> <u>\$14,700</u> N/A	<u>)</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	<del>\$50</del>	
Health care		_	
orovider's office or	Other practitioner office visit	<del>\$50</del> <u>\$35</u>	
clinic visit	Specialist visit	\$ <del>90</del> <u>\$85</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	<del>\$19</del>	
Orugs to treat	Tier 2	\$55	Pharma deductib
liness or	Tier 3	<b>¢</b> 0 <i>E</i>	Pharma
condition	noi o	\$85	deductik
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductik
Outpatient	Surgery facility fee (e.g., ASC)	30%	
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	<del>\$450</del> \$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	<del>\$50</del> \$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	30% 30%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office		
nealth, behavioral nealth, or	visits	<del>\$50</del>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	<del>\$50</del> <u>\$35</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Uolo	Outpatient Rehabilitation and Habilitation services	\$50 <u>\$35</u>	
Help recovering or	·		,
other special health needs	Skilled nursing care	30%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	•		
Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

### 2024 2025 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: July 20, 2023 April 18, 2024

Summary	of.	Benefits	and	Coverage

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
otuorial V-l	V Calculator	04.40/.00.00/		04.00/.00.0	0/-
ctuarial Value - A				<del>64.9%</del> <u>63.6</u>	
	· ·		nacy	Yes, integral	
	-			\$7,050 <u>\$6,650</u> int	-
			:4E0 / ¢0	<del>\$14,100</del> <u>\$13,300</u> ir	ntegrated
				N/A N/A	
		·	_	N/A \$7,050 \$6,6	50
	·			<del>\$1,000</del> \$0,0	
	• •		U	<del>\$7,050</del> \$6,6	
				\$7,050 \$6,6	
		Member Cost Share	Deductible Applies	Member Cost Share	Deduc
Event		082	After 1st three non-		Appli X
			After 1st three non-	0%	×
		<b>400</b>	'	<b>3</b> 70	
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Plane assign encludes a deductable integrated individual deductable integrated individual deductable integrated individual deductable individual deductable. NOT integrated family deductable individual deductable. NOT integrated family deductable individual deductable. NOT integrated family deductable individual collectable. NOT integrated family deductable individual deductable individual collectable. NOT integrated family deductable individual deductable individual deductable. NOT integrated family deductable individual deductable individual deductable. NOT integrated family deductable individual		0%	X		
	0%	×			
	Imaging (CT/PET scans, MRIs)	40%	X	0%	×
	Tier 1	<u>\$17</u> .\$10	Pharmacy Deductible	A00	х
	nor i			U 70	*
	Tier 2			0%	×
	Tier 3	40% up to \$500 per script after	Pharmacy	0%	×
-CHARLOH	2			J /0	^
	Tier 4			0%	×
	Surgery facility fee (e.g. ASC)		Y	0%	×
Outpatient					
ervices	, ,				×
	Outpatient visit	40%	X	0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0	×
	Emergency room facility fee (waived if admitted)	40%	X	0%	×
	Emergency room physician fee (waived if admitted)	No charge		0%	×
	Medical transportation (including emergency and non-emergency)	40%	X	0%	×
ttention	Urgent care	\$60		0%	×
		400/.	<b>v</b>	09/	X
lospital stay					
	Physician/surgeon fee	40%	X	0%	X
nealth,		\$60		0%	×
substance		\$60		0%	×
	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	×	0%	×
				0%	, X
ther special	Skilled nursing care	40%	X	0%	×
eaith needs	Durable medical equipment	40%	X	0%	×
	Hospice service	No charge		0%	×
hild eye	Eye exam	No charge		No charge	
-	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
		- J		Ü	
	-				
Diagnostic	•	Not Covered		Not Covered	
na Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Net Correct		Not Court	
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental		N 10		N · O	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child					

	ents and coverage				
ummary of Benefits and Coverage ember Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan		
ctuarial Value - AV	/ Calculator				
ituariai value - Av	Plan design includes a deductible?	Yes,	integrated		
	Integrated Individual deductible	\$9,450 <u>\$9,200</u> integrated			
	Integrated Family deductible	\$18,900 <u>\$1</u>	18,400 integrated		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
	Individual Out-of-pocket maximum				
	Family Out-of-pocket maximum  HSA plan: Self-only coverage deductible	<del>\$18,9</del>	100 <u>\$18,400</u> N/A		
	HSA family plan: Individual deductible		N/A		
Common Medical	Service Type	Member Cost Share	Deductible Appli		
Event	Primary care visit to treat an injury, illness, or condition	0%	After 1st three n		
Health care provider's	Other practitioner office visit	0%	After 1st three n		
office or	Chariellist visit	00/	preventive visi		
clinic visit	Specialist visit	0%	X		
	Preventive care/ screening/ immunization	No charge 0%	X		
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	0%	X		
. 0313	A-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%	×		
	Tier 1	0%	X		
Drugs to treat	Tier 2	0%	X		
illness or condition	Tier 3	0%	X		
	Tier 4	0%	×		
Outpatient	Surgery facility fee (e.g., ASC)  Physician/surgeon fees	0%	X		
services	Outpatient visit	0%	×		
	Emergency room facility fee (waived if admitted)	0%	X		
	Emergency room physician fee (waived if admitted)	No charge	^		
Need	Medical transportation (including emergency and non-emergency)	0%	X		
immediate attention	ggg,g,	070			
attention	Urgent care	0%	After 1st three n		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	00/	\		
Hospital stay	delivery, mental health, and substance use)	0%	X		
	Physician/surgeon fee	0%	X		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three n		
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	x		
Pregnancy	Prenatal care and preconception visits	No charge			
	Home health care (cost share per visit)	0%	х		
Help	Outpatient Rehabilitation and Habilitation services	0%	x		
recovering or other special	Skilled nursing care	0%	x		
health needs	Durable medical equipment	0%	x		
	Hospice service	0%	x		
Child eye	Eye exam	No charge			
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	x		
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Com			
and Preventive	Sealants per Tooth	Not Covered			
i reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not C:			
Basic Services	Periodontal Maintenance Services	Not Covered			
	Crowns and Casts				
Child Daniel	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered			
Services	Prosthodontics				
			I .		

Oral Surgery

Medically necessary orthodontics

Not Covered

	efits and Coverage	CA E. L. OCT C''	10 1 C 1 C 1	CA E 00E 0"	7 DI
Member Cost Share amounts describe the Enrollee's out of pocket costs.		CA Enh CSR Silver 94 Plan 100%-150% FPL		CA Enh CSR Silver 87 Plan 150%-200% FPL	
Actuarial Value - AV Calculator		<del>94.7%</del> <u>95.1%</u>		88.8% <u>88.9%</u>	
Plan design includes a deductible?				Nο	
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum			\$3,000	
	Family Out-of-pocket maximum			\$6,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
Cillic visit	·				
	Preventive care/ screening/ immunization	No charge		No charge	
Toete	Laboratory Tests  Y rays and Diagnostic Imaging	\$8		\$20 \$40	
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	
illness or condition	Tier 3	\$15		\$45	
condition	5			<b>\$10</b>	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient services	Physician/surgeon fees	10%		20%	
Services	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention		,,,,			
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		20%	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral	visits	ΨΟ		Ψισ	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$5		\$15	
abuse needs	items and services			•	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%		20%	
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child	Eye exam	No charge		No charge	
Child eye care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	590		. 10 0.10.190	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		Not Covered		Not Covered	
Preventive	Sealants per Tooth  Topical Eliveride Application				
	Topical Fluoride Application				
Child Dontal	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 7		
Simpor Good Gildaro	anicalia accente dia Elitance cata periodi cacci.	Above 200% FPI	L	
ctuarial Value - A\	/ Calculator	<del>79.5%</del> <u>79.2%</u>		
	Plan design includes a deductible?	No		
	Integrated Individual deductible	N/A		
	Integrated Family deductible	N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0 \$0 / \$0 / \$0		
Family Out-of-pocket maximum  HSA plan: Self-only coverage deductible		\$12,200		
		N/A		
	HSA family plan: Individual deductible	N/A		
Common Medical Event	Service Type	Member Cost Share	Deductib Applies	
	Primary care visit to treat an injury, illness, or condition	\$35		
Health care provider's	Other practitioner office visit	\$35		
office or				
clinic visit	Specialist visit	\$85		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$50		
Tests	X-rays and Diagnostic Imaging	\$95		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$15		
	Tier 2	A		
Drugs to treat	Tier 2	\$55		
condition	Tier 3	\$85		
	Tier 4	20% up to \$250 per script		
Outpatient	Surgery facility fee (e.g., ASC)	30%		
services	Physician/surgeon fees	30%		
	Outpatient visit	30%		
	Emergency room facility fee (waived if admitted)	\$350		
	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	30%		
Hospital stay	delivery, mental health, and substance use)			
	Physician/surgeon fee	30%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35		
behavioral	visits	,		
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		
	Home health care (cost share per visit)	\$40		
Help	Outpatient Rehabilitation and Habilitation services	\$35		
recovering or	Skilled nursing care	30%		
other special health needs	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
Child Door	Preventive - Cleaning			
Child Dental Diagnostic	Preventive - X-ray	Not O		
and Preventive	Sealants per Tooth	Not Covered		
rievelluve	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic	Periodontal Maintenance Services	Not Covered		
Services				
	Crowns and Casts			
Child Dental	Endodontics			
Major Services	Periodontics (other than maintenance)	Not Covered		
OCI VICES	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	Not Covered		

#### Endnotes to Covered California 2025 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 2025 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) Where indicated, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, and/or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2025 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, Podiatrists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided

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

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

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2025 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.
- 32) These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.