### Covered California 2026 Patient-Centered Benefit Plan Designs<sup>1</sup>

Final Approved

April 16, 2025

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

# 2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 April 17, 2025



	Summary of Benefits and Coverage		TM				
-	amounts describe the Enrollee's out of pocket costs.	Individual-only I		Individual-only F			
nombol Good Gridio	amounto accessize and Emoneto eat of position coole.	Coinsurance	Plan	Copay Pla	an		
Actuarial Value - A	V Calculator	91.9%		91.8%			
totuariai value - A	Plan design includes a deductible?			No			
	Integrated Individual deductible	\$0		\$0			
	Integrated muvidual deductible	\$0		\$0			
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	:0	\$0 / \$0 / \$	:n		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$		\$0 / \$0 / \$			
	Individual Out-of-pocket maximum			\$5,000			
	Family Out-of-pocket maximum			\$10,000			
	HSA plan: Self-only coverage deductible			N/A			
	HSA family plan: Individual deductible			N/A			
Common		Mambar Cost	D. J. Will	Mambar Coat	D. J		
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies		
Lvent	Primary care visit to treat an injury, illness, or condition	\$15		\$15			
Health care	, , , , , , , , , , , , , , , , , , , ,	***					
provider's	Other practitioner office visit	\$15		\$15			
office or clinic visit	Specialist visit	\$30		\$30			
	Preventive care/ screening/ immunization	No charge		No charge			
	Laboratory Tests	\$15		\$15			
Tests	X-rays and Diagnostic Imaging	\$30		\$30			
Tests							
	Imaging (CT/PET scans, MRIs)	10%		\$75			
	Tier 1	\$9		\$9			
Description	Tier 2	\$16		\$16			
Drugs to treat illness	1101 2	Ψ10		Ψ10			
or condition	Tier 3	\$25		\$25			
	Tier 4	10% up to \$250 per		10% up to \$250 per			
	1161 4	script		script			
	Surgery facility fee (e.g., ASC)	10%		\$75			
Outpatient services	Physician/surgeon fees	10%		\$20			
Sel Vices	Outpatient visit	10%		10%			
	Emergency room facility fee (waived if admitted)	\$175		\$175			
	Emergency room physician fee (waived if admitted)						
Need		No charge		No charge			
immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150			
attention							
	Urgent care	\$15		\$15			
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$225 per day up to			
Hospital stay	delivery, mental health, and substance use)	100/		5 days			
	Physician/surgeon fee	10%		No charge			
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15			
behavioral	VISILS						
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15			
abuse needs	items and services						
Pregnancy	Prenatal care and preconception visits	No charge		No charge			
	Home health care (cost share per visit)	10%		\$20			
Help							
	Outpatient Rehabilitation and Habilitation services	\$15		\$15			
recovering or other	Outpatient Rehabilitation and Habilitation services Skilled nursing care	\$15 10%		\$125 per day up to			
recovering or other special	Skilled nursing care	10%		\$125 per day up to 5 days			
recovering or other	Skilled nursing care  Durable medical equipment	10% 10%		\$125 per day up to 5 days 10%			
recovering or other special	Skilled nursing care  Durable medical equipment  Hospice service	10% 10% No charge		\$125 per day up to 5 days 10% No charge			
recovering or other special health needs Child eye	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam	10% 10% No charge No charge		\$125 per day up to 5 days 10% No charge			
recovering or other special health needs	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	10% 10% No charge		\$125 per day up to 5 days 10% No charge			
recovering or other special health needs Child eye	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam	10% 10% No charge No charge		\$125 per day up to 5 days 10% No charge			
recovering or other special health needs Child eye care	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	10% 10% No charge No charge		\$125 per day up to 5 days 10% No charge			
recovering or other special health needs Child eye care	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning	10% 10% No charge No charge		\$125 per day up to 5 days 10% No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  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	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge No charge			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts  Endodontics	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge No charge See 2025 Dental Copay Schedule			
recovering or other special health needs  Child eye care  Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major	Skilled nursing care  Durable medical equipment  Hospice service  Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontal Maintenance Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)	10% 10% No charge No charge No charge		\$125 per day up to 5 days 10% No charge No charge No charge No charge See 2025 Dental Copay Schedule			

## 2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 April 17, 2025

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	i I	CCSB-onl Platinum Copay Pla	í
uarial Value - A	W Calculator	91.8%		91.1%	
uariai value - A	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum			\$4,500	
	Family Out-of-pocket maximum			\$9,000	
	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	Member Cost Share	Deduc App
event	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
lealth care	Other practitioner office visit	\$15		\$20	
orovider's office or	·	φισ		Ψ20	
linic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
	Tier 2				
Drugs to treat illness or condition		\$25		\$20	
	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$150		\$150	
mmediate	wedien transportation (motiving emergency and non-emergency)	\$150		\$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%		\$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	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
ecovering or other				\$150 per day up to	
special	Skilled nursing care	10%		5 days	
nealth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye				No charge	
•	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge			
•	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	No charge			
•		No charge			
care	Oral Exam Preventive - Cleaning	No charge			
care Child Dental Diagnostic	Oral Exam Preventive - Cleaning Preventive - X-ray	No charge		No charge	
care  Child Dental  Diagnostic	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	, ,		No charge	
care  Child Dental  Diagnostic	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	, ,		No charge	
care  Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	, ,		No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge		See 2025 Dental	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	, ,			
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	No charge		See 2025 Dental	
Child Dental Diagnostic and Preventive Child Dental Basic Services	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services	No charge		See 2025 Dental Copay Schedule	
Child Dental Diagnostic and Preventive  Child Dental Basic Services  Child Dental Major	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts	No charge		See 2025 Dental Copay Schedule See 2025 Dental	
Child Dental Diagnostic and Preventive Child Dental Basic Gervices Child Dental	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	No charge		See 2025 Dental Copay Schedule	
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	No charge		See 2025 Dental Copay Schedule See 2025 Dental	

## 2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 April 17, 2025

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - A		81.4%		81.7%	
	Plan design includes a deductible? Integrated Individual deductible	No \$0		No \$0	
	Integrated individual deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	60
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$9,200		\$9,200	
	Family Out-of-pocket maximum	\$18,400		\$18,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
loolth oore	Primary care visit to treat an injury, illness, or condition	\$40		\$40	
Health care provider's office or clinic visit	Other practitioner office visit	\$40		\$40	
	Specialist visit	\$70		\$70	
	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	\$18		\$18	
Orugs to	Tier 2	\$60		\$60	
treat illness	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%		\$130	
Outpatient	Physician/surgeon fees	30%		\$60	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
	medical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$40		\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		\$375 per day up to	
Hospital stay	delivery, mental health, and substance use)  Physician/surgeon fee	30%		5 days No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$40		\$40	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40		\$40	
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	\$40		\$40	
recovering or other	Skilled nursing care	30%		\$150 per day up to	
special health needs	Durable medical equipment	20%		5 days 20%	
nearth needs	Hospice service				
	Eye exam	No charge		No charge	
Child eye care	·	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental	
Services	Periodontal Maintenance Services			Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics			San 2025 D- 11	
Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay Schedule	
Services	Prosthodontics			. ,	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1.000	

Summary of Benefits and Coverage		CCSB-only		CCSB-only		
-	amounts describe the Enrollee's out of pocket costs.	Gold		Gold		
		Coinsurance Pla	n	Copay Plan		
Actuarial Value - A	V Calculator	80.3%		81.7%		
Actualiai value - A						
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm N/A	асу	Yes, Medical/Pharr	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		
	Family Out-of-pocket maximum			\$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	Member Cost Share	Deductible	
Event			Applies		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	Carlot production of the viola	Ψ20		ΨΟΟ		
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%			v	
	illaging (CT/FET Scans, WRIS)	20%		\$250	Х	
	Tier 1	\$15		\$15		
B	Tier 2	\$50		\$40		
Drugs to treat illness	1.5. 2	ΨΟΟ		Ψ+0		
or condition	Tier 3	\$80		\$70		
	Tion 4	000/ / 0050				
	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%		
			V		V	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х	
attention						
	Urgent care	\$25		\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and					
Hospital stay	delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	X	
	Physician/surgeon fee	20%	X	No charge		
Mental	Mental/behavioral health and substance use disorder outpatient office					
health, behavioral	visits	\$25		\$35		
health, or	Na					
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35		
		No observe		No oberge		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
Help recovering	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
or other	Skilled nursing care	20%	x	\$300 per day up to 5 days	x	
special health needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
and	Sealants per Tooth	No charge		No charge		
Preventive						
	Topical Fluoride Application					
•	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental Copay		
Services	Periodontal Maintenance Services	2070		Schedule		
	Crowns and Casts					
	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay		
Services		JU 70		Schedule		
	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		

ilibei Cost Silale	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
		<b>-4.00</b> /	
tuarial Value - A		71.8%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm N/A	acy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0	)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$9,800	
	Family Out-of-pocket maximum	\$19,600	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductibl Applies
	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	
omno vion	Preventive care/ screening/ immunization		
	Laboratory Tests	No charge \$50	
Tests	X-rays and Diagnostic Imaging		
. 50.6	Imaging (CT/PET scans, MRIs)	\$95 \$325	
		\$325	
	Tier 1	\$19	
Drugs to	Tier 2	\$60	Pharma deductib
treat illness	Tier 3	<b>¢</b> 00	Pharma
or condition	no o	\$90	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductik
D	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$50	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	30% 30%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
health, or 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	Skilled nursing care	30%	X
special nealth needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	-	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge No charge	
	Oral Exam	ivo cilalge	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
01.11.1	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%	
GEI VILES	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

	<del>, 202</del> 4 <u>April 17, 2025</u>				
Summary of Ber	nefits and Coverage	CCSB-only Silver		CCSB-only Silver	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plar	1	Copay Plan	
Actuarial Value - A	V Calculator	71.2%		70.8%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$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	
	HSA family plan: Individual deductible			N/A	
Common			5		5
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	<b>Ф</b> ГГ		<b>\$</b> FF	
Health care	Fillinary care visit to treat an injury, illiness, or condition	\$55		\$55	
provider's	Other practitioner office visit	\$55		\$55	
office or clinic visit	Specialist visit	\$90		\$90	
Cillic visit		·			
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
Tests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	Х	\$300	Х
	Tier 1	\$20		\$19	
		φ∠∪		و ا پ	
Drugs to	Tier 2	\$75	Pharmacy deductible	\$85	Pharmacy deductible
treat illness	Tion 2	<b>0405</b>	Pharmacy	<b>6440</b>	Pharmacy
or condition	Tier 3	\$105	deductible	\$110	deductible
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script	Pharmacy
		pharmacy deductible	deductible	after 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%	Х	35%	Х
	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	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	35%	Х	35%	Х
Hospital stay	delivery, mental health, and substance use)				,
	Physician/surgeon fee	35%	X	35%	
Mental health.	Mental/behavioral health and substance use disorder outpatient office	\$55		\$55	
behavioral	visits	Ψ00		400	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	фгг		ф.г.	
abuse needs	items and services	\$55		\$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	35%		\$45	
Help					
recovering	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
or other special	Skilled nursing care	35%	X	35%	Х
health needs	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
Ot the	Eye exam	No charge		No charge	
Child eye care		_		_	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child D	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	N		,	
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Daniel					
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental Copay	
Services	Periodontal Maintenance Services			Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay	
Services	Prosthodontics			Schedule	
01	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 April 17, 2025 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 70.6% Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$3,200 integrated Integrated Family deductible \$6,400 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A Individual Out-of-pocket maximum \$8,300 Family Out-of-pocket maximum \$16,600 HSA plan: Self-only coverage deductible \$3,200 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 clinic visit Specialist visit 25% Preventive care/ screening/ immunization No charge 25% 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 Drugs to treat illness Х script 25% up to \$250 per or 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) 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 Help Outpatient Rehabilitation and Habilitation services 25% Х recovering or other Skilled nursing care 25% Х special health needs Durable medical equipment 25% Hospice service 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 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)

Medically necessary orthodontics

Prosthodontics Oral Surgery

50%

50%

Summary of Benefits and Coverage	Summar	v of Benefits	and Coverage
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ember Cost Share a	efits and Coverage amounts describe the Enrollee's out of pocket costs.	<b>Silver P</b> 100%-1509		<b>Silver Plan</b> 150%-200% FPL	
ctuarial Value - AV	Calculator	94.8%	6	87.9%	
	Plan design includes a deductible?	No		Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$1,400 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$2,800 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$1,40		\$3,350 \$6,700	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible			\$6,700 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
Lvoiit	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or	Constitute de de	0.0		405	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$10		\$30	
Tests	X-rays and Diagnostic Imaging	\$10		\$50	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
Davis	Tier 2	\$10		\$25	Pharmacy
Drugs to treat illness	1101 2	\$10		φ20	deductible
or condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient	Physician/surgeon fees	10%		20%	
services	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
Need mmediate attention	modical transportation (modaling emergency and non-emergency)	φ30		Ψισ	
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	400/		9994	.,
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10% 10%		20%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$5		\$15	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other				20%	x
special	Skilled nursing care	10%			^
health 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				
Child Dante	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 Glaige		140 Glaige	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	222/		222	
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
		50%		50%	
Major	Periodontics (other than maintenance)  Prosthodontics  Oral Surgery	50%		50%	

	nefits and Coverage		
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPI	_
tuarial Value - A'	V Calculator	73.8%	
	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	\$5,200 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$10,400 / \$100 / \$ \$8,100	<b>Б</b> О
	Family Out-of-pocket maximum	\$16,200	
	HSA plan: Self-only coverage deductible	\$10,200 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	\$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	\$19	
Druge to	Tier 2	\$55	Pharma
Drugs to treat illness			deductil Pharma
or condition	Tier 3	\$85	deductik
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductil
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$50	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	30% 30%	х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
health, or 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)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other	Skilled nursing care	30%	×
special			^
health needs	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		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	20 /0	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		

Medically necessary orthodontics

Summary	ν of	Renefits	and	Coverage

Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	Bronze HDHP Plan	
Actuarial Value - A	V Calculator	63.7%		64.8%		
	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integral	ed	
	-	N/A	пасу	-		
	Integrated Individual deductible	N/A		\$7,200 integra		
	Integrated Family deductible		20	\$14,400 integr	aleu	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$		N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /	\$0	N/A		
	Individual Out-of-pocket maximum	\$9,800		\$7,200		
	Family Out-of-pocket maximum	\$19,600		\$14,400		
	HSA plan: Self-only coverage deductible	N/A N/A		\$7,200		
	HSA family plan: Individual deductible	e IN/A		\$7,200		
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	\$60		0%	X	
Health care provider's	Other practitioner office visit	\$60		0%	X	
office or	0	405	After 1st three non-	201	.,	
clinic visit	Specialist visit	\$95	preventive visits	0%	X	
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$50		0%	X	
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X	
	Imaging (CT/PET scans, MRIs)	40%	x	0%	х	
	Tier 1	\$20		0%	x	
				U 70	^	
Drugs to	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X	
treat illness	Tior 3	40% up to \$500 per script after	Pharmacy	00/		
or condition	Tier 3	pharmacy deductible	Deductible	0%	X	
	Tier 4	40% up to \$500 per script after	Pharmacy	0%	x	
	0 ( ) ( ) ( ) ( ) ( )	pharmacy deductible	Deductible			
Outpatient	Surgery facility fee (e.g., ASC)	40%	X	0%	X	
services	Physician/surgeon fees	40%	X	0%	X	
	Outpatient visit	40%	X	0%	X	
	Emergency room facility fee (waived if admitted)	40%	X	0%	X	
	Emergency room physician fee (waived if admitted)	No charge		0%	X	
Need	Medical transportation (including emergency and non-emergency)	40%	x	0%	x	
immediate	1 ( 3 3 )	.073		0,0	,	
attention		***		201	.,	
	Urgent care	\$60		0%	X	
Hannital star.	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	×	0%	X	
Hospital stay	Physician/surgeon fee	40%	x	0%	X	
Mental	Mental/behavioral health and substance use disorder outpatient office					
health,	visits	\$60		0%	X	
behavioral health, or						
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	Х	
	Prenatal care and preconception visits	No oborgo		No charge		
Pregnancy	Prenatal care and preconception visits  Home health care (cost share per visit)	No charge	V	No charge	V	
Holo	Home health care (cost share per visit)	40%	X	0%	X	
Help recovering	Outpatient Rehabilitation and Habilitation services	\$60		0%	X	
or other special	Skilled nursing care	40%	X	0%	х	
health needs	Durable medical equipment	40%	x	0%	х	
	Hospice service	No charge		0%	x	
Child ave	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	. 15 5/lai go		, 10 C. Idi go		
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	No charge		No charge		
and Preventive	Sealants per Tooth	Ŭ				
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	20%		20%		
OUI VICES	Crowns and Casts					
Child Dental	Endodontics					
Major Services	Periodontics (other than maintenance)	50%		50%		
	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	50%		50%		
Orthodontics						

Summar	of Benefits a	nd Coverage
Oullinu	or Deficines as	ia coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible		io integrated
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$20,30	00 integrated N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	\$	10,150
	Family Out-of-pocket maximum	\$	20,300
	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	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%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	Х
	Tier 1	0%	х
Drugs to	Tier 2	0%	x
treat illness or condition	Tier 3	0%	X
or condition			
	Tier 4	0%	Х
Outurations.	Surgery facility fee (e.g., ASC)	0%	X
Outpatient services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	0%	X
attention			After 1st three non-
	Urgent care	0%	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	Mental/behavioral health and substance use disorder outpatient office	070	After 1st three non-
health, behavioral	visits	0%	preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	x
abuse needs	items and services	070	^
Pregnancy	Prenatal care and preconception visits	No charge	
Hali	Home health care (cost share per visit)	0%	X
Help recovering	Outpatient Rehabilitation and Habilitation services	0%	Х
or other special	Skilled nursing care	0%	Х
health needs	Durable medical equipment	0%	Х
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed		
Basic	Restorative Procedures	0%	Х
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics  Periodontics (other than maintenance)	00/	_
Major Services	Periodontics (other than maintenance)	0%	X
	Prosthodontics Oral Surgery		
Child	Oral Surgery	001	V
Orthodontics	Medically necessary orthodontics	0%	X

### 2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18 2024 April 17 2025

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil 100%-1509		CA Enh CSR Silver 8 150%-200% FPL	
tuarial Value - A'	W Calculator	<del>95.1%</del> <u>9</u> 5	: 40/	<del>88.9%</del> <u>89.6%</u>	
luariai value - A	Plan design includes a deductible?	99.170 <u>90</u> No	<u> </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	\$1,15	0	\$3,000	
	Family Out-of-pocket maximum	\$2,30	0	\$6,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
2	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc App
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
lealth care provider's	Other practitioner office visit	\$5		\$15	
ffice or					
linic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
ests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
rugs to	Tier 2	\$10		\$25	
treat illness or condition	Tier 3	\$15		\$45	
Condition		10% up to \$150		ψ <del>1</del> 0	
	Tier 4	per script		15% up to \$150 per script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		20%	
ervices	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	
leed	Medical transportation (including emergency and non-emergency)	\$30		\$75	
mmediate	1 ( 3 3 )	Ψοσ		Ų. S	
ittention	Urgent care	\$5		\$15	
lospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	
	Physician/surgeon fee	10%		20%	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ehavioral nealth, or	Violid				
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
buse needs regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
łelp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
ecovering					
or other special	Skilled nursing care	10%		20%	
ealth needs	Durable medical equipment	10%		15%	
	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				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	'				
	Topical Fluoride Application				
Neila D	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
	J ,				

## 2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 April 17, 2025

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Above 200% FPI	
tuarial Value - A		<del>79.2%</del> <u>80.4%</u>	
	Plan design includes a deductible? Integrated Individual deductible	No 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 plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductil Applie
Event	Primary care visit to treat an injury, illness, or condition	\$35	
Health care			
provider's office or	Other practitioner office visit	\$35	
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	
Drugs to treat illness	Tier 2	\$55	
or condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
00.7.000	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	
Haanital atau	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	
Hospital stay	Physician/surgeon fee	30%	
Mental	Mental/behavioral health and substance use disorder outpatient office		
health, behavioral	visits	\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$35	
abuse needs	items and services	φυσ	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help recovering	Outpatient Rehabilitation and Habilitation services	\$35	
or other	Skilled nursing care	30%	
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		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	No charge	
i revenuve	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics		

9.5 EHB





Summary of Bei	nefits and Coverage	TI	А		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only I		Individual-only F	
		Coinsurance	Plan	Copay Pla	ın
Actuarial Value - A	V Calculator	91.9%		91.8%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	in.	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	10	\$0 / \$0 / \$	U
	Individual Out–of–pocket maximum	\$5,000		\$5,000	
	Family Out-of-pocket maximum	\$10,000		\$10,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common					
Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event		Charo		Citaro	
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care	Other and this are officer visit	0.45		0.45	
provider's office or	Other practitioner office visit	\$15		\$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	
	5 5 ( · · · · · · · · · · · · · · · · ·	1370		Ψίσ	
	Tier 1	\$9		\$9	
	Ti				
Drugs to	Tier 2	\$16		\$16	
treat illness or condition	Tier 3	\$25		\$25	
J. Johnson	•	Ψ20		Ψ20	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
		script		script	
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient	Physician/surgeon fees	10%		\$20	
services	•				
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$175		\$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need					
immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention					
	Urgent care	\$15		\$15	
				****	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$225 per day up to 5 days	
Hospital stay	Physician/surgeon fee	10%		No charge	
	i ilysidali/surgeon lee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$15	
behavioral	visits	Ψισ		ψ10	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering					
or other	Skilled nursing care	10%		\$125 per day up to 5 days	
special health needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	N-+ 0 :		Net O	
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	·				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic	Periodontal Maintenance Services	Not Covered		Not Covered	
Services					
	Crowns and Casts				
06.11.1.7	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	,	110t Govereu		, sot Govered	
	Prosthodontics				
	Oral Surgery				
Child		Not Course !		Not Course !	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

## 2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB Date: April 18, 2024 April 17, 2025

ummary of Be	s <mark>, 2024 April 17, 2025</mark> nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Platinum Coinsurance		CCSB-on Platinum Copay Pla	í
ctuarial Value - A	V Calculator	91.8%		91.1%	
ctuariai value - A	Plan design includes a deductible?			91.176 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	
0	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's office or	Other practitioner office visit	\$15		\$20	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
	Tier 2	\$25		\$20	
Drugs to treat illness or condition	Tier 3	\$40		\$30	
or condition		10% up to \$250 per		\$30 10% up to \$250 per	
	Tier 4	script		script	
Outpotiont	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate attention	Urgent care	\$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%		\$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 other	Skilled nursing care	10%		\$150 per day up to	
special health needs	Durable medical equipment	10%		5 days 10%	
	Hospice service				
		No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	No charge		No charge	
	Preventive - Cleaning				
Child Dental	-				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
a	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	
_ 0 1003	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

## 2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB Date: April 18, 2024 April 17, 2025

Print despited interfeding despited print decided described integrated Federal described in Print despited described in integrated Employ described in Print decided described in integrated Metals of Printing of Printing 19 (19 ) 20 20 20 20 20 20 20 20 20 20 20 20 20	ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
Plan design instruction and education with processes and education in the processes of processes and			- Comountaines		Sopu, i i	
Private   Priv	ctuarial Value - A	V Calculator	81.4%		81.7%	
Indicational conductation, NOI integrated family demands   100		Plan design includes a deductible?	No		No	
Individual deviation   Family documents   Not 1 integrated Medical / Pinaminay / Daried   10 / 10 / 10 / 10 / 10 / 10 / 10 / 10		Integrated Individual deductible				
Family desketible, NOT integrated Medical Pleanurs (1994) 1994 190 180   98 180 180   180 180 180   180 180 180   180 180 180   180 180 180   180 180 180   180 180 180   180 180 180   180 180 180 180   180 180 180 180   180 180 180 180 180   180 180 180 180 180 180 180 180 180 180		• ,			·	
Private Common   1986 part						
Principal Common		• • • • • • • • • • • • • • • • • • • •		)		50
Common   No.   N		· ·				
Member Cost Shaw   December   Member Cost Shaw   Park						
Common Medical   Service Type   Member Cost Share   Discussion   Dis						
Pierre Creek Person Carle Health Carle Creek Health Carle College praced to the test an injury, limeas, or condoton Health Carle College praced to the test an injury, limeas, or condoton Health Carle College praced to the condition of the college process of the college proce	Common			Doductible	Mombor Cost	Dodusti
Neath case of the precision of the visit of the provision		Service Type	Member Cost Share			Applie
Secondaries of Specialist visid Speciali		Primary care visit to treat an injury, illness, or condition	\$40		\$40	
clinic visit    Specialist visit   Specialist visit   Stock		Other and the same of the same of	0.40		0.40	
Preventive carel screening immunization Laboratory Tests Laboratory Tests Array and Diagnostic imaging Imaging (CTPPET scare, NRTs) Imaging (CTPPET scare, NRTs) Ter 1 Ter 2 Ter 2 Sept. Ter 1 Ter 2 Sept. Ter 3 Sept. S		Other practitioner office visit	\$40		\$40	
Laboratory Tests  X-rays and Dagnostic Imaging Imaging (CT/PET soans, MRIs)  Tor 1  Tor 1  Tor 1  Tor 2  S80  S80  S80  Tor 3  Tor 3  Tor 3  S85  S85  S85  S85  S85  S85  S85  S8	clinic visit	Specialist visit	\$70		\$70	
X-rays and Diagnostic Imaging   \$75   \$7		Preventive care/ screening/ immunization	No charge		No charge	
Imaging (CT/PET scans, Mills)  Ter 1  Ter 1  Tier 1  Tier 2  Sago		Laboratory Tests	\$40		\$40	
Tier 1 Tier 2 Tier 2 Tier 2 Tier 3 Tier 3 Tier 4 Tier 3 Tier 4 Tier 3 Tier 4 Tier 5 Tier 4 Tier 4 Tier 4 Tier 4 Tier 4 Tier 5 Tier 4 Tier 4 Tier 5 Tier 4 Tier 4 Tier 5 Tier 4 Tier 5 Tier 4 Tier 4 Tier 4 Tier 5 Tier 5 Tier 4 Tier 5 Tier 4 Tier 5 Tier 5 Tier 6 Tier 7 Ti	lests .	X-rays and Diagnostic Imaging	\$75		\$75	
Tiler 2 S80 S80 S80 S80 Teast tillness Teast S80		Imaging (CT/PET scans, MRIs)	25%		\$75	
Tier 2 S80 S80 S80 S80 Tier 3 S85 S85 S85 Tier 3 S85 S85 Tier 4 Stronditions Tier 4 St		Tier 1	\$18		\$18	
Tree 4 20% up to \$250 per script 20% up to \$			*		***	
Tier 3 Tier 3 Tier 4 Ti		Tier 2	\$60		\$60	
Tier 4  Surgery facility fee (e.g., ASC)  Physician/surgeon fees  Outpatient viet  Competent viet  Emergency room facility fee (way-well if admitted)  Emergency room facility fee (way-well if admitted)  Emergency room physician fee (waived if admitted)  Emergency room physician fee (waived if admitted)  Medical transportation (including emergency and non-emergency)  Urgent core  Facility fee (e.g., hospital stay  feelopital stay  Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee  Wentall health, and substance use disorder outpatient office viets  which are and services  Physician viet and substance use disorder outpatient office viets  which are and services  Pregnancy  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled muraing care  Child Dental Basic  Basic  Breventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluctured Application  Space Maintainers - Fixed  Child Dental Basic  Barrices  Child Dental Basic  Barrices  Child Dental Basic  Barrices  Periodontal Maintenance Services  Crowns and Casts  Enclodentics  Periodontal Maintenance Services  Crowns and Casts  Enclodentics  Periodontal Maintenance)  Proventices  Crowns and Casts  Enclodentics  Periodontal Maintenance)  Proventices  Crowns and Casts  Enclodentics  Periodontal Kaintenance)  Proventices  Crowns and Casts  Enclodentics  Crowns and Casts  Encloadentics  Crowns and Casts  Enclodentics  Crowns and Casts  Encloadentics  Crowns and Casts  Encloadentics  Crowns and Casts  E		Tier 3	\$85		\$85	
Outpatient terrices  Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient viert  Emergency room facility fee (walved if admitted)  No charge  Emergency room physician fee (walved if admitted)  No charge  No charge  Medical transportation (including emergency and non-emergency)  Urgent care  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery; mental health, and substance use)  Physician/surgeon fee  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Mental health, or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health, or behavioral health and substance use disorder outpatient office valis  Montal health or behavioral health and substance use disorder outpatient office valis  Holp recreased and preconception visits  No charge  No cha			20% up to \$250 per		20% up to \$250	
Outpatient visit  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)  No charge  Medical transportation (including emergency and non-emergency)  Urgent care  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, or or 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  Holip Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Joursale Rehabilitation and Habilitation services  Skilled nursing care  Skilled nursing care  No charge  No charge  No charge  Perventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Florioride Application  Space Martalaners - Fixed  Molt Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Periodoricis (other than maintenance)  Prosthodoricis  Oral Surgery		Tier 4				
Prysician/surgeon fees   30%   \$30%		Surgery facility fee (e.g., ASC)	30%		\$130	
Cutpatient visit  Cutpatient visit  Cutpatient visit  Emergency room facility fee (waived if admitted)  Emergency room physician fee (waived if admitted)  No charge  No charge  No charge  No charge  No charge  Add  Medical transportation (including emergency and non-emergency)  Lirgent care  Utrgent care  S40  S40  S40  S40  S40  S40  S40  S4		Physician/surgeon fees	30%		\$60	
Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted)  No charge  No charge  No charge  \$250  \$25	services	Outpatient visit	20%			
Emergency room physician fee (walved if admitted)   No charge   S250   S250   S250						
Medical transportation (including emergency and non-emergency)  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee  Montal health, or 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 other outpatient litems 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  Skilled nursing care  Skilled nursing care  Whospice service  No charge						
tattention  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee  Montal health, phashioral 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 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 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 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 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 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 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 Montal/behavioral health and substance use disorder outpatient office visits Montal/behavioral health and substance use disorder outpatient office visits Montal/behavioral health	Nood		_		_	
Urgent care	mmediate	wedical transportation (including emergency and non-emergency)	\$250		\$250	
Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Montal 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 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 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  N	attention					
Hebpital stay Physician/surgeon fee Mental health, and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder 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 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 No charge No ch		Urgent care	\$40		\$40	
Hespital stay Physician/surgeon fee Mental health, behavioral health, or substance shubs a needs Pregnancy Prenatal care and preconception 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 items and services 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 visubstance Mental/behavioral health and substance use disorder outpatient S40  \$40  \$40  \$40  \$40  \$40  \$40  \$40					0.75	
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 Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service No charge Not Covered Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Hosnital stav		30%			
health, behathoral beh	1103pital Stay	Physician/surgeon fee	30%		No charge	
health, obbahavioral health, or bleath, or bleath, or bleath wisits  Mental/behavioral health and substance use disorder other outpatient lems and services  Pregnancy  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  \$40  Stilled nursing care  Skilled nursing care  Skilled nursing care  Skilled nursing care  Skilled nursing care  Ourable medical equipment  Hospice service  No charge  Preyeam  Preventive  Oral Exam  Preventive - Claaning  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		Mental/behavioral health and substance use disorder outpatient office				
Mental/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 Special Durable medical equipment Hospice service  Child Dental Diagnostic and Preventive Preventive Child Dental Basic Services Crowns and Casts Endodontics Prosthodontics Oral Surgery  Mental/behavioral health and substance use disorder other outpatient items and services No charge			\$40		\$40	
stubsuse needs items and services  Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Precovering or other special health needs Durable medical equipment Hospice service  Child dye care  Child Dental Diagnostic and Preventive Preventive  Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Child Dental Basic Services  Crowns and Casts Endodontics Child Dental Major Services  Items and services  No charge No charge Not Covered	health, or	Mental/behavioral health and substance use disorder other outpatient				
Help recovering or other special health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care Skok charge No charge No charge No charge No charge Not Covered Not Covered Not Covered Not Cover			\$40		\$40	
Help recovering or other special process or special pealth needs or other special pealth needs o	Pregnancy	Prenatal care and preconception visits	No charge		No charge	
recovering or other special por other special pacition of the page		Home health care (cost share per visit)	20%		\$30	
Skilled nursing care or other special health needs Durable medical equipment Hospice service No charge No		Outpatient Rehabilitation and Habilitation services	\$40		\$40	
Special health needs Durable medical equipment Durable Mocharge No charge Not Covered Proventive - X-ray Not Covered Not Covered Not Covered Proventive - X-ray Not Covered Not Co	_				\$150 per day up to	
Hospice service  Eye exam  I pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  No charge	special	·			5 days	
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  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery  No charge  No charge  No charge  No charge  No charge  Not Covered	nearth needs					
1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Oral Exam Preventive - Cleaning Preventive - 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 Not Covered			-		-	
Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Prosthodontics Oral Surgery  Child Dental Major Services  Prosthodontics  Oral Surgery  Not Covered Not Cov	-		-		_	
Child Dental Diagnostic and Preventive - Cleaning Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Periodontal Maintenance Services  Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery  Not Covered	care		No charge		No charge	
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Child Dental Major Services Child Dental Major Services Oral Surgery  Preventive - X-ray  Not Covered Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered		Oral Exam				
Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services  Child Dental Major Services Periodontics Oral Surgery  Not Covered  Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered	Child Dont-I	Preventive - Cleaning				
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services  Child Dental Major Servi		Preventive - X-ray	Not Covered		Not Covered	
Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  Topical Fluoride Application Space Maintainers - Fixed  Not Covered Not Covered  Not Covered  Not Covered  Not Covered		Sealants per Tooth	1101 Covered		1101 Govereu	
Child Dental Restorative Procedures Periodontal Maintenance Services  Crowns and Casts  Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  Not Covered  Not Covered  Not Covered  Not Covered  Not Covered		Topical Fluoride Application				
Basic Services Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered		Space Maintainers - Fixed				
Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery  Not Covered Not Covered		Restorative Procedures				
Child Dental Major Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Oral Surgery  Crowns and Casts  Endodontics  Not Covered  Not Covered			Not Covered		Not Covered	
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery  Endodontics Not Covered Not Covered						
Child Dental Major Periodontics (other than maintenance) Not Covered Not Covered Prosthodontics Oral Surgery						
Services Prosthodontics Oral Surgery			Not Covers		Not Cover-	
Oral Surgery Oral Surgery		,	NOL Covered		NOT Covered	
Child Medically passagery orthodoptics		Oral Surgery				

9.5 EHB

Summary of Be	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Pla	n	CCSB-only Gold Copay Plan	
Actuarial Value - A		80.3%		81.7%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm N/A	acy	Yes, Medical/Pharr	macy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care provider's	Other practitioner office visit	\$25		\$35	
office or clinic visit	Specialist visit	\$50		\$55	
Cilillo Viole	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55 \$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
	Tier 1				
	irea i	<b>\$15</b>		\$15	
Drugs to	Tier 2	\$50		\$40	
treat illness or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	20%	×	\$250	X
attention	Urgent care	\$25		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	20% 20%	x x	\$600 per day up to 5 days	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
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	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
recovering or other	Skilled nursing care	20%	×	\$300 per day up to 5 days	X
special health needs	Durable medical equipment	20%		20%	,
nouth needs	Hospice service	20% No charge		No charge	
Object	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	90			
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
53111303	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics	,,				

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
tuarial Value - A		71.8%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharm N/A	acy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0	)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	\$0
	Individual Out-of-pocket maximum	\$9,800	
	Family Out-of-pocket maximum	\$19,600	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductibl
Event	Primary care visit to treat an injury, illness, or condition	\$50	Applies
Health care	Other practitioner office visit	\$50	
provider's office or	Other practitioner office visit	\$50	
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	\$19	
			Pharmad
Drugs to treat illness	Tier 2	\$60	deductib
or condition	Tier 3	\$90	Pharmad deductib
	Tion 4	20% up to \$250 per script	Pharmad
	Tier 4	after pharmacy deductible	deductib
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	30%	X
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$50	
behavioral	visits	ΨΟΟ	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$50	
abuse needs	items and services	ΨΟΟ	
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	Skilled nursing care	30%	х
special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	_	
	1 pair or glasses per year (or contact lenses in lieu or glasses)  Oral Exam	No charge	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Restorative Procedures  Basic Not Covered		Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
			1

Summary of Bei	nefits and Coverage  amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plar		CCSB-only Silver Copay Plan	
		Consulance Fiai	•	оорау гтап	
Actuarial Value - A		71.2%		70.8%	
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharma	acy	Yes, Medical/Pharm	acy
	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 / \$	0
	Individual Out-of-pocket maximum	\$8,600		\$8,750	
	Family Out-of-pocket maximum	\$17,200		\$17,500	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care provider's	Other practitioner office visit	\$55		\$55	
office or	0	•••			
clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
Tests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	Х	\$300	X
	Tier 1	\$20		\$19	
	Tier 2	\$75	Pharmacy	\$85	Pharmacy
Drugs to treat illness		Ψίσ	deductible	φοσ	deductible
or condition	Tier 3	\$105	Pharmacy deductible	\$110	Pharmacy deductible
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	35%	Х	35%	Х
Outpatient services	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	Х	35%	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	35%	X	35%	Х
immediate attention	Urgent care	\$55		\$55	
	Facility foe /o g. beenitel room) for innations etay / including labor and				
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	35% 35%	x x	35% 35%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$55		\$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	<b>\$55</b>		\$55	
recovering or other	Skilled nursing care	35%	×	35%	X
special			^		^
health needs	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
ou. e	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not Coursed		Not Coursed	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Prostnodontics  Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB Date: April 18, 2024 April 17, 2025 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 70.6% Plan design includes a deductible? Yes, integrated Integrated Individual deductible \$3,200 integrated Integrated Family deductible \$6,400 integrated Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A Family deductible, NOT integrated: Medical / Pharmacy / Dental N/A Individual Out-of-pocket maximum \$8,300 Family Out-of-pocket maximum \$16,600 HSA plan: Self-only coverage deductible \$3,200 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% 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 Drugs to treat illness Х script 25% up to \$250 per or 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) 25% Emergency room physician fee (waived if admitted) 0% Х Need Medical transportation (including emergency and non-emergency) 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 Help Outpatient Rehabilitation and Habilitation services 25% Х recovering or other Skilled nursing care 25% Х special health needs Durable medical equipment 25% Hospice service 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

Summary	of Benefits	and Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	<b>Silver F</b> 100%-150		<b>Silver Plan</b> 150%-200% FPI	
ctuarial Value - A	V Calculator	94.89	6	87.9%	
	Plan design includes a deductible?	No		Yes, Medical/Pharm	nacv
	Integrated Individual deductible	N/A		N/A	,
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0	\$0	\$1,400 / \$50 / \$0	)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$2,800 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$1,40	0	\$3,350	
	Family Out-of-pocket maximum	\$2,80	0	\$6,700	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	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	
_	Laboratory Tests	\$10		\$30	
Tests	X-rays and Diagnostic Imaging	\$10		\$50	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
	Tier 2	<b>640</b>		605	Pharmacy
Drugs to treat illness	Her 2	\$10		\$25	deductible
or condition	Tier 3	\$15		\$45	Pharmacy deductible
		10% up to \$150			Pharmacy
	Tier 4	per script		15% up to \$150 per script	deductible
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient services	Physician/surgeon fees	10%		20%	
501 11005	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate	modela transportation (modeling emorgency and non-emorgency)	ΨΟΟ		Ψίδ	
attention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	400/		000/	
Hospital stay	delivery, mental health, and substance use)	10%		20%	X
	Physician/surgeon fee	10%		20%	
Mental health.	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral	visits	Ψ0		<b>\$10</b>	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
abuse needs		No observe		No about	
Pregnancy	Prenatal care and preconception visits  Home health care (cost share per visit)	No charge \$3		No charge \$15	
Help					
recovering	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
or other special	Skilled nursing care	10%		20%	X
health 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	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				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child		Not Course !		Not Coursed	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

### 2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB Date: April 18 2024 April 17 2025

Summary of Benefits and Coverage  Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 200%-250% FPL	
tuarial Value - A		73.8%	
Plan design includes a deductible? Integrated Individual deductible		Yes, Medical/Pharm N/A	iacy
	Integrated Framily deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0	)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	60
	Individual Out–of–pocket maximum	\$8,100	
	Family Out-of-pocket maximum	\$16,200	
	HSA plan: Self-only coverage deductible	N/A N/A	
Common Medical	HSA family plan: Individual deductible Service Type	Member Cost Share	Deductib Applies
Event	Primary care visit to treat an injury, illness, or condition	\$50	
Health care			
provider's office or	Other practitioner office visit	\$50	
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	\$19	
	Tier 2	<b>*</b> FF	Pharma
Drugs to treat illness	Tier 2	\$55	deductil
or condition	Tier 3	\$85	Pharma deductil
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductil
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
Services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	Х
Hospital stay	delivery, mental health, and substance use)  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)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other	Skilled nursing care	30%	х
special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child ave	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	110 Silaigo	
	Preventive - Cleaning		
Child Dental	Preventive - Creaning Preventive - X-ray		
Diagnostic and		Not Covered	
Preventive	Sealants per Tooth  Topical Fluoride Application		
	Topical Fluoride Application  Space Maintainers - Fixed		
Child Dental	Space Maintainers - Fixed		
Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
	Periodontics (other than maintenance)	Not Covered	
Major Services	,	Not oovered	
Major	Prosthodontics Oral Surgery	Not Govered	

9.5 EHB

Summary	of	<b>Benefits</b>	and	Coverage
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Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze HDHP Plan	
Actuarial Value - AV Calculator		63.7%		64.8%	
	Plan design includes a deductible?	Yes, Medical/Pharn	nacv	Yes, integral	ted
	Integrated Individual deductible	N/A	пасу	\$7,200 integral	
_		N/A			
Integrated Family deductible				\$14,400 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$		N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 / \$0		N/A	
	Individual Out-of-pocket maximum	\$9,800		\$7,200	
	Family Out-of-pocket maximum	\$19,600		\$14,400	
	HSA plan: Self-only coverage deductible	N/A		\$7,200	
	HSA family plan: Individual deductible	N/A		\$7,200	
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	\$60		0%	×
Health care provider's	Other practitioner office visit	\$60		0%	X
office or	0	405	After 1st three non-	201	.,
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$50		0%	Х
Tests	X-rays and Diagnostic Imaging	40%	X	0%	Х
	Imaging (CT/PET scans, MRIs)	40%	×	0%	x
	Tier 1	\$20		0%	X
Devent to	Tier 2	40% up to \$500 per script after	Pharmacy	0%	x
Drugs to treat illness	-	pharmacy deductible	Deductible	J 70	_ ^
or condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
		40% up to \$500 per script after	Pharmacy		
	Tier 4	pharmacy deductible	Deductible	0%	X
	Surgery facility fee (e.g., ASC)	40%	X	0%	Х
Outpatient	Physician/surgeon fees	40%	×	0%	X
services	Outpatient visit	40%	×	0%	x
	·				
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need	Medical transportation (including emergency and non-emergency)	40%	X	0%	Х
immediate attention					
	Urgent care	\$60		0%	×
	organi dara	ΨΟΟ		070	^
Hannital star.	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	X
Hospital stay	Physician/surgeon fee	40%	×	0%	X
Mental		1070	,	0,0	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	Х
behavioral health, or	1010				
substance	Mental/behavioral health and substance use disorder other outpatient	\$60		0%	X
abuse needs	items and services	• • •			
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	×	0%	x
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	X
recovering or other	Skilled nursing care	40%	×	0%	x
special					
health needs	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	X
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	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dontal	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	
uoinido					

9.5 EHB

Summar	of Benefits and Co	overage

Summary of Benefits and Coverage  Member Cost Share amounts describe the Enrollee's out of pocket costs.  Catastrophic Plan				
Actuarial Value - A	V Calculator			
	Plan design includes a deductible?	Yes,	integrated	
	Integrated Individual deductible		60 integrated	
	Integrated Family deductible	\$20,30	00 integrated N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental  Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
	Individual Out-of-pocket maximum	\$	10,150	
	Family Out-of-pocket maximum		20,300	
	HSA plan: Self-only coverage deductible	*	N/A	
	HSA family plan: Individual deductible		N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	
Event	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%	X	
Omno viole	Preventive care/ screening/ immunization		^	
	·	No charge 0%	X	
Tests	Laboratory Tests	0%		
resis	X-rays and Diagnostic Imaging		X	
	Imaging (CT/PET scans, MRIs)	0%	X	
	Tier 1	0%	X	
Drugs to	Tier 2	0%	×	
treat illness or condition	Tier 3	0%	×	
or condition	nor o	070	^	
	Tier 4	0%	x	
	Surgery facility fee (e.g., ASC)	0%	x	
Outpatient	Physician/surgeon fees	0%	X	
services	Outpatient visit	0%	x	
	Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	No charge		
Need	Medical transportation (including emergency and non-emergency)	0%	X	
immediate attention	gg	070	^	
attention	Urgent care	0%	After 1st three non-	
		0.0	preventive visits	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	00/	V	
Hospital stay	delivery, mental health, and substance use)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits	
behavioral health, or			proventive viole	
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		
Fregulaticy	Home health care (cost share per visit)	0%	X	
Help				
recovering	Outpatient Rehabilitation and Habilitation services	0%	X	
or other special	Skilled nursing care	0%	X	
health needs	Durable medical equipment	0%	X	
	Hospice service	0%	Х	
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray	Not Covered		
and Preventive	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services	5570104		
	Crowns and Casts			
Child Dental	Endodontics			
Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			
Child Orthodontics	Medically necessary orthodontics	Not Covered		
Orthoughtics				

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	
ctuarial Value - A	V Calculator	<del>95.1%</del> 9 <u>5</u>	5.4%	<del>88.9%</del> <u>89.6%</u>	
radial value 71	Plan design includes a deductible?	No	<u>,, , , , , , , , , , , , , , , , , , ,</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	
	Individual Out–of–pocket maximum Family Out-of-pocket maximum	\$1,15 \$2,30		\$3,000 \$6,000	
	HSA plan: Self-only coverage deductible	Ψ2,30 N/A	o .	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 Appl
	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	
Sillic Visit	Preventive care/ screening/ immunization				
	•	No charge		No charge	
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	\$8 \$8		\$20 \$40	
. 0313	A-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$8 \$50		\$40 \$100	
				·	
	Tier 1	\$3		\$5	
Drugs to	Tier 2	\$10		\$25	
reat illness or condition	Tier 3	\$15		\$45	
condition	·			ψ-το	
	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%	
Sel VICES	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					
attornion	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 health,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral	visits	<del></del>			
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other	Skilled nursing care	10%		20%	
special health needs	Durable medical equipment	10%		15%	
.outil Heeus	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	140 Glarye		ino charge	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics  Desiredentias (other than maintenance)	Net O.		N-4 O	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				

## 2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB Date: April 18, 2024 April 17, 2025

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Pla Above 200% FPL	
(- 11) (  - A	W0.1.1.	70.00/.00.40/	
tuarial Value - A	v Calculator  Plan design includes a deductible?	<del>79.2%</del> <u>80.4%</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 plan: Self-only coverage deductible	N/A	
Common	HSA family plan: Individual deductible	N/A	Dadwati
Medical Event	Service Type	Member Cost Share	Deductil Applie
Health care	Primary care visit to treat an injury, illness, or condition	\$35	
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	
	nor I	CIG	
Drugs to	Tier 2	\$55	
treat illness or condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
00.11000	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	Mental/behavioral health and substance use disorder outpatient office	40-	
health, behavioral	visits	\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	<b>#</b> 25	
abuse needs	items and services	\$35	
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 other	Skilled nursing care	30%	
special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Obild	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	140 Glarge	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
01.11.5	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
COI VICES	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

#### **Endnotes to Covered California 2026 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 2026 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, and glasses (or contact lenses in lieu of glasses) under Child Eye Care.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2026 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:

Tier	Definition
1	Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
2	Any other drugs recommended by the plan's
	pharmaceutical and therapeutics (P&T) committee based on
	drug safety, efficacy and cost.
	1) Non-preferred brand name drugs or;
3	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.
	1) Drugs that the Food and Drug Administration (FDA) or
4	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 2026 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.