Covered California 2026 Patient-Centered Benefit Plan Designs¹

Proposed

February 20, 2025

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

Date: April 18, 2024 February 20, 2025

Summary of Benefits and Coverage



mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
tuarial Value - AV	/ Calculator	91.9%		91.6% <u>91.8</u>	<u>3%</u>
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$4,500 \$5,0	000	\$,4500 \$5,0	000
	Family Out-of-pocket maximum	\$9,000 \$10,	000	\$9,000 \$10,0	000
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care 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	
Tooto					
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$7 \$9		\$7 \$9	
Drugs to treat	Tier 2	\$16		\$16	
illness or					
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient	Physician/surgeon fees	10%		\$20	
services		10%		10%	
	Outpatient visit				
	Emergency room facility fee (waived if admitted)	\$150 \$175		\$150 \$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate attention	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	100/		\$225 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
· ognancy		_			
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
ecovering or other special	Skilled nursing care	10%		\$125 per day up to 5 days	
nealth needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
	·	-		-	
Child eye	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
N. 11.1 5	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	·				
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental	
Services	Periodontal Maintenance Services			Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See 2025 Dental	
Services	Prosthodontics			Copay Schedule	
	Oral Surgery				
Child	Oral Surgery	50%		\$1,000	

	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-oni Platinum Coinsurance	ĺ	CCSB-onl Platinum Copay Pla	Ī
ctuarial Value - A	V Calculator	91.3% <u>91.8</u>	8%	90.5% <u>91.1</u>	%
iotaanar varab 71	Plan design includes a deductible?	No	<u></u>	No	<u>70</u>
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's 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 10% up to \$250 per		\$30 10% up to \$250 per	
	Tier 4	script		script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$100	
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 immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	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	Skilled nursing care	10%		\$150 per day up to	
other special health needs	·			5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
A	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	, , ,		, , ,	
and Preventive	Sealants per Tooth	No charge		No charge	
. revenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2025 Dontal	
Basic	Periodontal Maintenance Services	20%		See 2025 Dental Copay Schedule	
Services					
	Crowns and Casts				
Child Dental	Endodontics			See 2025 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
OC! VICES	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	
Orthodontics		30 70		ψ1,000	

Medical Service Type Member Cost Share Applies Share Applies Share Applies Cost Share Applies Share Share Applies Share Share Applies Share Ap	ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance I		Individual-only Copay Pla	
Interview of the Control 100	ctuarial Value - A	V Calculator	81.5% <u>81.4</u>	<u>%</u>	81.6% 81.7	<u>'%</u>
Individual detectable, NOT integrated Medical / Plannary / Oursil Family detectable, NOT integrated Medical / Plannary / Oursil Pamily detectable, NOT integrated Medical / Plannary / Oursil Pamily detectable, NOT integrated Medical / Plannary / Oursil Pamily detectable, NOT integrated Medical / Plannary / Oursil Pamily detectable, NOT integrated Medical / Plannary / Oursil Pamily detectable Plannary / Oursil Plannary /		Plan design includes a deductible?	No		No	
Princy care visit to liend an injury interest introduced in Principle of Montal Pri		Integrated Individual deductible	\$0		\$0	
Family deductible, NOT integrated Newland (Pharmany) Chertal (Pharma		Integrated Family deductible	\$0		\$0	
Partly Cht-4-deckar motimum Pa		Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
Principal Common 157,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18,400 \$18		Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
Common HSA from Self-orly coverage desteation NA NA NA HSA from Self-orly coverage desteation of the Self-orly named to treat an injury, illness, or condition Self-orly named to treat an injury, illness, or condition Self-orly named to treat an injury, illness, or condition No charge Self-orly No charge Self-orly No charge No Charge No No charge No No charge No Charge No No charge No Charge No No charge No No charge No No charge No Charge No No charge No No charge No No charge No No charge No Charge No No char		Individual Out-of-pocket maximum	\$8,700 <u>\$9,20</u>	<u>00</u>	\$ 8,700 <u>\$9,2</u>	200
Marchaet		Family Out-of-pocket maximum	\$17,400 <u>\$18.4</u>	<u> 100</u>	\$17,400 <u>\$18.</u>	400
Member Cost Share Member						
Ferrany care visit to frest an injury, lithress, or condition Ferrany care visit to frest an injury, lithress, or condition Offer practitions of files visit Specialist visit Preventive carel screening immunitation Incitia Visit August and Diagnosis Imaging Incitia Visit Incitia Visi	Medical				Member Cost	Dedu
Control of the practice of the shall be control of the practice of the shall be control of the shall b	Event	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$40</u>	7 400		7.45
clinic visit Preventive carel accentrage immunization See \$70 See \$70		Other practitioner office visit	\$35 \$40		\$35 \$40	
Preventive care' screening' immunication Laboratory Tests Laboratory Tests Arrays and Diagnostic imaging Imaging (CTPET acens, MRIs) Tier 1 First 2 Tier 1 First 3 Tier 2 S80 S85 S85 S86 S86 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physicianteurgeon fees Culpateur visit Emergency room facility fee (waved if admitted) Culpateur visit Emergency room facility fee (waved if admitted) Ligent care S85 S86 S86 S86 S86 S86 S86 S86	office or	•				
Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scare, MRIs) Ter 1 Ter 2 \$00 \$00 \$00 \$00 Ter 3 Ter 2 \$00 \$00 \$00 Ter 3 \$00 \$00 \$00 \$00 \$00 Ter 3 \$00 \$00 \$00 \$00 \$00 \$00 Ter 3 \$00 \$00 \$00 \$00 \$00 \$00 \$00 \$	clinic visit	Specialist visit	\$65 \$70		\$65 \$70	
Arays and Diagnostic Imaging \$75		Preventive care/ screening/ immunization	No charge		No charge	
Imaging (CT/PET scans, MRIs) Ter 1 Ter 1 Set 518 Tier 2 Tier 3 Set 519 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fee 5296 Set 5296 Physician/surgeon fee 5296 Set 5296 Set 5206 Emergency room facility fee (walved if admitted) Set 5206 Emergency room physician fee (walved if admitted) Set 5207 Set 5208 Set 5209 Set 5200 Set		Laboratory Tests	\$40		\$40	
Titer 1	Tests	X-rays and Diagnostic Imaging	\$75		\$75	
Tier 2 Tier 3 Tier 3 Tier 4 Tier 4 Tier 3 Tier 4 Tier 4 Tier 3 Tier 4 Tier 4 Tier 5 Tier 4 Tier 6 Tier 5 Tier 4 Tier 6 Tier 7 Tier 8 Tier 8 Tier 4 Tier 8 Tier 9 Ti		Imaging (CT/PET scans, MRIs)	25%		\$75	
Tier 3 Tier 4 Tier 3 Tier 4 Tier 3 Singery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room facility fee (wilved if admitted) Emergency room facility fee (wilved if admitted) Emergency room physician fee (walved if admitted) Emergency room physician fee (walved if admitted) Emergency room physician fee (walved if admitted) Medical transportation (including emergency) Vigent care Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Wental health health and substance use disorder outpatient office value and substance use disorder outpatient office value. Wental health health and substance use disorder outpatient office value. Wental health health and substance use disorder outpatient times and services. Wental health health and substance use disorder outpatient office value. Wental health health and substance use disorder outpatient times and services. Wental health health and substance use disorder outpatient times and services. Wental health health and substance use disorder outpatient times. Wental health health and substance use disorder outpatient times. Wental health care (cost share per visit) Outpatient Fabribilitation and Habitiation services Sisted outpatient fabribilitation and Habitiation services Sisted outpatient fabribilitation and Habitiation services No charge View exam View example outpatient No charge Preventive - Cleaning Preventive		Tier 1	\$15 \$18		\$15 \$18	
Illinois or Condition Ter 3 Sas5 Sas5 Sas5 Sas5 Ter 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient services Outpatient viet Emergency room facility fee (waved if admitted) Emergency room facility fee (waved if admitted) Emergency room facility fee (waved if admitted) Emergency room physician fee (waved if admitted) Urgent care Sas0 Sas0 Sas0 Sas0 Sas0 Sas0 Sas0 Sas0 Sas0 Sas0 Sas0 Sas0 No charge No charge Hospital stay Physician/surgeon fees Wental transportation (including emergency and non-emergency) Urgent care Sas6 Sec0 Sas0 Sas0 No charge Sas6 Sec0 Sas6 S	Drugs to treat	Tier 2	\$60		\$60	
Tier 4 20% up to \$250 per script 20% up to \$	illness or	Tier 3	\$85		\$85	
Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge Medical transportation (including emergency and non-emergency) Medical transportation (including emergency and non-emergency) Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits No charge Preventive and precording or visits No charge Sa5 540 S						
Dutpatient services Outpatient visit Cutpatient visit Dutpatient visit Cutpatient visit Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge No charge No charge S250 S250 R250 Hospital stay Hospital stay Physician/surgeon fee Medical transportation (including emergency and non-emergency) Lirgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health, or 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 literia and services Pregnancy Prenatal care and preconception visits Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Jurable medical equipment Hospice service Durable medical equipment Hospice service No charge Preventive - Kray Sealonts per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontiks (other than maintenance) Prosthodontics Prosthodontics Prosthodontics Prosthodontics Prosthodontics Prosthodontics Prosthodontics		Tier 4				
Dupatient visit Final and precomption facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge No charge No charge No charge Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgence fee Mentall Mental/behavioral health and substance use disorder outpatient office visits Programary Pregnancy Prenatal care and preconception visits No charge Holp Sabs \$40 Sabs \$		Surgery facility fee (e.g., ASC)	30%		\$130	
Coupatient visit Coupatient visit Coupatient visit Coupatient visit Coupatient visit Coupatient visit Coupatient Rehabilitation Coupatient		Physician/surgeon fees	30%		\$60	
Emergency room physician fee (waived if admitted) No charge \$250		Outpatient visit	20%		20%	
Emergency room physician fee (waived if admitted) No charge S250		Emergency room facility fee (waived if admitted)	\$330 \$350		\$330 \$350	
Medical transportation (including emergency and non-emergency) Urgent care S35 \$40 S36 \$40 S35 \$40 S35 \$40 S35 \$40 S35 \$40 S35 \$40 S35 \$40 S36 \$40 S37 \$40 S37 \$40 S38 \$40 S38 \$40 S38 \$40 S39 \$40 S40 \$40			No charge		No charge	
Immediate attention Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services Mental/behavioral health and substance use disorder outpatient times and services No charge Child Dental Basic Services Crowns and Casts Endodontics Endodontics Periodontal Maintenance Services Crowns and Casts Endodontics Periodontal Maintenance) Prosthodontics No cherge See 2025 Dental Copay Schedule	Need		\$250			
Urgent care \$36 \$40 \$35 \$40			Ψ200		Ψ200	
delivery, mental health, and substance use) Physician/surgeon fee Mental health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient items and services 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 office visuals and services No charge Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Prosthodontics Prosthodontics	attention	Urgent care	\$ 35 <u>\$40</u>		\$35 <u>\$40</u>	
Mental health, health, or substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Pregnancy Prenatal care and preconception visits No charge No charge No charge Skilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice service Durable medical equipment Preventive Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Previothodontics Periodontics (other than maintenance) Prosthodontics	Hospital stay	delivery, mental health, and substance use)			up to 5 days	
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 Sabs \$40 Sabs \$	health,		\$35 <u>\$40</u>			
Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Safe \$40 Safe	health, or substance		\$35 <u>\$40</u>		\$35 <u>\$40</u>	
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Oral Exam Preventive - Cleaning Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Service Services Child Dental Basic Service Service Service Service Servi		Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special nealth needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Restorative Procedures Services Child Dental Restorative Procedures Child Dental Restorative Procedures Child Dental Restorative Procedures Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Skilled nursing care 30% \$36 \$40 \$150 per day up to 5 days 20% No charge See 2025 Dental Copay Schedule	ognancy					
Skilled nursing care other special health needs Durable medical equipment						
other special health needs Durable medical equipment Hospice service Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - A-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Child Dental Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Skilled nursing care 30% 5 days 20% No charge No charge No charge No charge No charge No charge See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule Prosthodontics		Outpatient Rehabilitation and Habilitation services	\$35 <u>\$40</u>			
Durable medical equipment Hospice service No charge Child Dental Diagnostic and 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 Prosthodontics	other special	Skilled nursing care	30%			
Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Prosthodontics Prosthodontics No charge No charge No charge No charge No charge No charge Se No charge	nealth needs	Durable medical equipment	20%		20%	
1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics No charge See 2025 Dental Copay Schedule		Hospice service	No charge		No charge	
Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics No charge	Child eve	Eye exam	No charge		No charge	
Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics Prosthodontics	-	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental 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 Prosthodontics Prosthodontics Prosthodontics Prosthodontics No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule			-		-	
Child Dental 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 Prosthodontics Prosthodontics Prosthodontics Prosthodontics No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule		Preventive - Cleaning				
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics Prosthodontics						
Preventive Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Child Dental Basic Services Crowns and Casts Endodontics Periodontics Periodontics (other than maintenance) Prosthodontics Prosthodontics Prosthodontics		•	No charge		No charge	
Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Space Maintainers - Fixed 20% See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule						
Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics Periodontics Periodontics Endodontics Periodontics Periodontics (other than maintenance) Prosthodontics Prosthodontics		•				
Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Prosthodontics See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	Child Dont-					
Crowns and Casts Endodontics Periodontics Child Dental Major Services Prosthodontics Prosthodontics See 2025 Dental Copay Schedule	Basic		20%			
Child Dental Major Services Endodontics Periodontics (other than maintenance) Prosthodontics Endodontics See 2025 Dental Copay Schedule	Services				, ,	
Child Dental Major Services Prosthodontics (other than maintenance) Periodontics (other than maintenance) See 2025 Dental Copay Schedule						
Major Periodontics (other than maintenance) 50% Copay Schedule Prosthodontics					See 2025 Dental	
Prosthodontics		Periodontics (other than maintenance)	50%			
Oral Surgery	_ 3003	Prosthodontics				
		Oral Surgery				

•	nefits and Coverage	CCSB-only		CCSB-only	
-	amounts describe the Enrollee's out of pocket costs.	Gold		Gold	
member deet enare t	anio di constito di la Entrata di catta i postitati conte.	Coinsurance Pla	n	Copay Plan	
Actuarial Value - A\	/ Calculator	79.1% <u>80.3%</u>		80.5% <u>81.7%</u>	
/ totalina variab / to	Plan design includes a deductible?		acv	Yes, Medical/Phari	
	Integrated Individual deductible	N/A	acy	N/A	Пасу
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common	A		Deductible		Deductible
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care	0.1				
provider's office or	Other practitioner office visit	\$25		\$35	
clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
					,
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$40	
illness or					
condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$300	X
services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	X	\$250	X
immediate attention				·	
attention	Urgent care	\$25		\$35	
	orgeni care	φ23		φυσ	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	X
oop.iii. oiiiy	Physician/surgeon fee	20%	X	No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$25		\$35	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
g.i.u.i.o,	Home health care (cost share per visit)	20%		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	Ų.		Ü	
	Preventive - Cleaning				
Child Dental					
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental Copay	
Basic Services	Periodontal Maintenance Services	ZU%		Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay	
Services	Prosthodontics			Schedule	
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

-	nefits and Coverage	la dividual auto Cibas	. Diam
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	rPian
Actuarial Value - A	√ Calculator	71.6% <u>71.8%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 <u>\$5,200</u> / \$50	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 <u>\$10,400</u> / \$10	00 / \$0
	Individual Out-of-pocket maximum	\$8,700 \$9,800 \$17,400 \$40 600	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$17,400 <u>\$19,600</u> N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care provider's	Other practitioner office visit	\$50	
office or	·		
clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$18 <u>\$19</u>	
	Tier 2	# 00	Pharmacy
Drugs to treat illness or	Hell 2	\$60	deductible
condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy
	1161 4	after pharmacy deductible	deductible
0.4	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	30%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	
Mental		30 70	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
behavioral 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	
	Outpatient Rehabilitation and Habilitation services	\$50	
Help recovering or			
other special health needs	Skilled nursing care	30%	Х
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	20%	
Basic Services	Periodontal Maintenance Services	∠0%	
	Crowns and Casts		
Child Daniel	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	
Orthodontics		JU /0	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver		CCSB-only Silver	
		Coinsurance Plar		Copay Plan	
Actuarial Value - A\	/ Calculator	69.5% <u>71.2%</u>		69.1% <u>70.8%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	асу
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0)	\$2,500 / \$300 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$	
	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	Consideration in the contract of the contract	400		200	
clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
Tests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	X	\$300	X
	Tier 1	\$20		\$19	
Drugs to treat	Tier 2	\$75	Pharmacy	\$85	Pharmacy
illness or		Ų. S	deductible Pharmacy	·	deductible Pharmacy
condition	Tier 3	\$105	deductible	\$110	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
Outurations.	Surgery facility fee (e.g., ASC)	35%	X	35%	Х
Outpatient services	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	X	35%	Х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	non-emergency) 35% X 35%	35%	Х	
	Urgent care	\$55		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	35%	X	35%	Х
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	35%	Х	35%	
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	\$55		\$55	
recovering or	Skilled nursing care	35%	x	35%	Х
other special health needs	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
OL:	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 Glarge		140 Glaige	
	Preventive - Cleaning				
Child Dental					
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Child Dontal	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental Copay Schedule	
Services	Periodontal Maintenance Services			Jonedaic	
	Crowns and Casts				
Child Dental	Endodontics			See 2025 Dental Copay	
Major Services	Periodontics (other than maintenance)	50%		Schedule Schedule	
J. 11003	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 February 20, 2025

=	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	•
tuarial Value - A	√ Calculator	71.2% <u>70</u>	.6%
	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$ 2,850 \$3,200 i	
	Integrated Family deductible	\$5,700 \$6,400 i	-
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$7,500 <u>\$8</u>	,300
	Family Out-of-pocket maximum	\$15,000 <u>\$1</u>	<u>6,600</u>
	HSA plan: Self-only coverage deductible	\$2,850)
Common	HSA family plan: Individual deductible	See endr	note
Medical Event	Service Type	Member Cost Share	Deductible Ap
Hoolth care	Primary care visit to treat an injury, illness, or condition	25%	X
Health care provider's	Other practitioner office visit	25%	х
office or clinic visit	Specialist visit	25%	×
Cillic visit	·		^
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	Х
	Tier 1	25% up to \$250 per	x
	Tion 2	script 25% up to \$250 per	
Drugs to treat illness or condition	Tier 2 Tier 3	script 25% up to \$250 per	×
	Tier 4	script 25% up to \$250 per	×
		script	
Outpatient	Surgery facility fee (e.g., ASC)	25%	X
services	Physician/surgeon fees	25%	X
	Outpatient visit	25%	X
	Emergency room facility fee (waived if admitted)	25%	X
	Emergency room physician fee (waived if admitted)	0%	x
Need immediate attention	Medical transportation (including emergency and non-emergency)	25%	х
	Urgent care	25%	х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	x
	Physician/surgeon fee	25%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	25%	×
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	x
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	х
Help	Outpatient Rehabilitation and Habilitation services	25%	×
recovering or	Skilled nursing care	25%	X
other special health needs	· ·		
	Durable medical equipment	25%	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)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic		20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child		50%	

Summary	, of	Renefite	and	Coverage
Sullilliai	<i>,</i> 01	Denenio	anu	Coverage

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPl	-
ctuarial Value - A\	V Calculator	94.7% <u>94</u>	. <u>8%</u>	88.0% <u>87.9%</u>	
	Plan design includes a deductible?	Yes, Medical/Ph	armacv No	Yes, Medical/Pharm	acv
	Integrated Individual deductible	N/A	, <u></u>	N/A	,
	Integrated Framily deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$1,400 / \$350 <u>\$50</u> /	\$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$2,800 / \$700 \$100	
					/ Φ0
	Individual Out-of-pocket maximum	\$,1300 <u>\$1</u>		\$3,050 <u>\$3,350</u>	
	Family Out-of-pocket maximum	\$2,600 <u>\$2</u>	<u>2,800</u>	\$6,100 <u>\$6,700</u>	
	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		Ψū		V. 0	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8 \$10		\$20 <u>\$30</u>	
Tests	X-rays and Diagnostic Imaging	\$8 \$10		\$40 \$50	
. 00.0				 -	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
illness or condition	Tier 3	\$15		\$45	Pharmacy
condition				\$10	deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC)	10%		20%	
services	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150 \$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need		_			
immediate	Medical transportation (including emergency and non-emergency)	\$30		\$75	
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%	×	20%	Х
Hospital stay	delivery, mental health, and substance use)		^		
	Physician/surgeon fee	10%		20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office 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			V		.,
other special health needs	Skilled nursing care	10%	X	20%	X
nearm 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	90		9 -	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 Glaige		ino cialge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
	• • • • • • • • • • • • • • • • • • • •				
Child Dental	Restorative Procedures			20%	
Child Dental Basic	Restorative Procedures	20%		2070	
	Periodontal Maintenance Services	20%		25%	
Basic	Periodontal Maintenance Services Crowns and Casts	20%		20%	
Basic Services Child Dental	Periodontal Maintenance Services Crowns and Casts Endodontics				
Basic Services Child Dental Major	Periodontal Maintenance Services Crowns and Casts	20%		50%	
Basic Services Child Dental	Periodontal Maintenance Services Crowns and Casts Endodontics				
Basic Services Child Dental Major	Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)				

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 February 20, 2025

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPI	L
tuarial Value - A		73.9% <u>73.8%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	пасу
	Integrated Individual deductible Integrated Family deductible	N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 <u>\$5,200</u> / \$350 <u>\$</u>	550 / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 \$10,400 / \$700	
	Individual Out-of-pocket maximum	\$7,350 <u>\$8,100</u>	
	Family Out-of-pocket maximum	\$14,700 <u>\$16,200</u>	<u>)</u>
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$50</u>	
Health care provider's	Other practitioner office visit	\$35 <u>\$50</u>	
office or clinic visit	Specialist visit	#95 #00	
Cillic visit	Specialist visit	\$85 <u>\$90</u>	
	Preventive care/ screening/ immunization	No charge	
Tosts	Laboratory Tests	\$50 \$05	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$20 <u>\$19</u>	
Drugs to treat	Tier 2	\$55	Pharma deductib
illness or condition	Tier 3	\$85	Pharma
Condition	1101.0		deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
Services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350 \$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention		1-22	
attention	Urgent care	\$35 <u>\$50</u>	
	o.gum vaio	φου <u>φου</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	Х
Hospital stay	delivery, mental health, and substance use)		X
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35 <u>\$50</u>	
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35 <u>\$50</u>	
Pregnancy	Prenatal care and preconception visits	No charge	
. rognancy	Home health care (cost share per visit)	\$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$50</u>	
other special health needs	Skilled nursing care	30%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	. to s.iai go	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	20%	
Basic Services	Periodontal Maintenance Services	∠U%	
	Crowns and Casts		
Child Danta	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

Date: April 18, 2024 February 20, 2025

Summary of Benefits and Coverage

lember Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
ctuarial Value - A\	/ Calculator	63.6% <u>63.7%</u>		64.9% <u>64.8</u>	<u>%</u>
	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integral	ted
	Integrated Individual deductible	N/A	-	\$6,650 <u>\$7,200</u> int	
	Integrated Family deductible	N/A		\$13,300 \$14,400 ir	•
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	50	N/A	g. a.o.
	Family deductible, NOT integrated: Medical / Pharmacy / Dental			N/A	
		\$11,600 / \$900 /		\$6,650 \$7,2	00
	Individual Out-of-pocket maximum	\$ 8,850 \$9,800			
	Family Out-of-pocket maximum	\$1,7700 \$19,60	0	\$13,300 \$14,	400
	HSA plan: Self-only coverage deductible	N/A		\$6,650	
Common	HSA family plan: Individual deductible	N/A		\$6,650	Deductible
Medical Event	Service Type Primary care visit to treat an injury, illness, or condition	Member Cost Share \$60	Deductible Applies	Member Cost Share	Applies
Health care	Filmary care visit to treat an injury, illness, or condition	200		0%	^
provider's	Other practitioner office visit	\$60		0%	Х
office or clinic visit	Specialist visit	\$95	After 1st three non-	0%	×
Cillic visit	·		preventive visits		^
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40 \$50		0%	X
Tests	X-rays and Diagnostic Imaging	40%	x	0%	х
	Imaging (CT/PET scans, MRIs)	40%	×	0%	x
	,				
	Tier 1	\$19 \$20		0%	X
Drugo to tract	Tier 2	40% up to \$500 per script after	Pharmacy	0%	x
Drugs to treat illness or		pharmacy deductible	Deductible		``
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%	X	0%	Х
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	х
Need	Medical transportation (including emergency and non-emergency)	40%	x	0%	x
immediate	,	¬V/V		7.0	
attention	Urgent care	\$60		0%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	×	0%	х
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	40%	X	0%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	Х
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	×	0%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$60		0%	X
other special	Skilled nursing care	40%	X	0%	X
health needs	Durable medical equipment	40%	×	0%	x
	Hospice service	No charge		0%	×
	•	-		-	^
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
Jul Alces					
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child	Oral Surgery				
Child	Medically necessary orthodontics	50%		50%	

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 February 20, 2025

Summary	of	Benefits	and	Coverage
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-	nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A	V Calculator		
iotaanai vaiao 71	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible		0,150 integrated
	Integrated Family deductible	\$18,400 <u>\$2</u>	0,300 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	\$9,2 9	00 <u>\$10150</u>
	Family Out-of-pocket maximum	\$18,4	00 \$20,300
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A
Common	Tio Claimy plan. marriada deddolloo	Marrie a Octob	1477
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-
office or		-	preventive visits
clinic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
Drugs to treat	Tier 2	0%	Х
illness or	Tier 3	00/	_
condition	Hel 3	0%	X
	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			
	Urgent care	0%	After 1st three non-
			preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	X
Hospital stay	delivery, mental health, and substance use)	0%	X
Mental	Physician/surgeon fee	0%	
health,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
behavioral health, or	Mantal/habayiaral haalth and substance use disorder ather sutration		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	×
recovering or	Skilled nursing care	0%	X
other special health needs	Durable medical equipment	0%	X
	Hospice service	0%	X
Child	Eye exam	No charge	, ,
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam	0.0	7.
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	0%	X
001 V1003	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	0%	x
Services	Prosthodontics		•
	Oral Surgery		
Child	Medically necessary orthodontics	0%	У
Orthodontics	modically necessary orthodolities	U 70	X

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18 2024 February 20 2025

Health care provider's office or clinic visit Tests Tests X. Drugs to treat illness or condition Ti Outpatient services En	Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A N/A	i <u>.4%</u>	88.9% <u>89.6%</u> No N/A	
Common Medical Event Price or Clinic visit Fests Condition Ti Conditi	Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	No N/A N/A	<u>4 70</u>	No	
Medical Event Present Presen	Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A N/A			
Medical Event Present Presen	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental			IN/A	
Medical Event Present Presen	Family deductible, NOT integrated: Medical / Pharmacy / Dental			N/A	
Medical Event Present Presen		\$0 / \$0 /	\$0	\$0 / \$0 / \$0	
Medical Event Present Presen	Individual Out of poolset maximum	\$0 / \$0 /	\$0	\$0 / \$0 / \$0	
Medical Event Present Presen	Individual Out-of-pocket maximum	\$1,150)	\$3,000	
Medical Event Present Presen	Family Out-of-pocket maximum	\$2,30)	\$6,000	
Medical Event Present Presen	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Health care provider's office or clinic visit Sp. Pr. La. Tests X. Im Ti. Drugs to treat liness or condition Ti. Dutpatient services O. E. Reed M. Meed M. Meed M. Pr. Pr. Pr. Pr. Pr. Pr. Pr. Pr. Pr. Pr	Service Type	Member Cost	Deductible	Member Cost Share	Deduc
lealth care provider's office or clinic visit or linic visit or li	Primary care visit to treat an injury, illness, or condition	Share \$5	Applies	\$15	Арр
orugs to treat Iness or ondition Dutpatient ervices Outpated Medical					
Process Space Spac	Other practitioner office visit	\$ 5		\$15	
Drugs to treat Iness or ondition Ti Dutpatient ervices Outpatent ervices Meed M	Specialist visit	\$8		\$25	
Prugs to treat Iness or ondition Ti Outpatient ervices Outpatient ervices Outpatient ervices Outpatient ervices Outpatient ervices	Preventive care/ screening/ immunization	No charge		No charge	
Orugs to treat Illness or Tiondition Ti Dutpatient Plervices O Entervices Meet Meet Meet Meet Meet Meet Meet Me	Laboratory Tests	\$8		\$20	
Drugs to treat Illness or condition Ti Dutpatient Prervices O	X-rays and Diagnostic Imaging	\$8		\$40	
Drugs to treat Iness or ondition Ti Dutpatient ervices Outpatent ervices Meed M	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Orugs to treat Iness or ondition Ti Dutpatient ervices O En	Tier 1	\$3		\$5	
Iness or treat Iness or ondition Ti Ti Dutpatient ervices O En	Tier 2	\$10		\$25	
Dutpatient Previces O				·	
Outpatient Pricervices O En	Tier 3	\$15		\$45	
Outpatient services O En	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
ervices O En	Surgery facility fee (e.g., ASC)	10%		20%	
Er Er	Physician/surgeon fees	10%		20%	
Er leed M	Outpatient visit	10%		20%	
leed M	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
ittention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
nealth, or Substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
	Prenatal care and preconception visits	No charge		No charge	
Н	Home health care (cost share per visit)	\$3		\$15	
	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
ecovering or	Skilled nursing care	10%		20%	
nealth needs					
וט	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
illiu eye	Eye exam	No charge		No charge	
are 1	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
0	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No obora-		No oborgo	
nd Se	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
S	Space Maintainers - Fixed				
Child Dental R	Restorative Procedures				
Basic	Periodontal Maintenance Services	20%		20%	
JC1 11000	Crowns and Casts				
Child Dental	Endodontics				
Services			1		
Pr	Periodontics (other than maintenance)	50%		50%	
Child	Prosthodontics	50%		50%	

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 February 20, 2025

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 7: Above 200% FPI	
tuarial Value - A\	/ Calculator	79.2% <u>80.4%</u>	
luariai value - A	Plan design includes a deductible?	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	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductik Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or 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		
	Her 1	\$15	
Drugs to treat	Tier 2	\$55	
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%	
	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	
	-		
Hannital atou	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 nealth, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
recovering or	·	30%	
other special nealth needs	Skilled nursing care		
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	20%	
Services			
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
Jei vices	Prosthodontics		
	Oral Surgery		
Child			

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Date: April 18, 2024 February 20, 2025

Summary of Benefits and Coverage



Summary of Ber	efits and Coverage	TI	А		
- -	amounts describe the Enrollee's out of pocket costs.	Individual-only F		Individual-only F	
		Coinsurance	Plan	Copay Pla	ın
Actuarial Value - A\	/ Calculator	91.9%		91.6% <u>91.8</u>	8%
Actuariar value - A		No		No	<u>770</u>
	Plan design includes a deductible? Integrated Individual deductible	\$0		\$0	
	Integrated mulvidual deductible	\$0		\$0	
		\$0 / \$0 / \$	·n	\$0 / \$0 / \$	0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental				
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$4,500 \$5,0		\$,4500 \$5,0	
	Family Out-of-pocket maximum	\$9,000 \$10,	000	\$9,000 \$10,0	000
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
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	
Toolo		·			
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$7 \$9		\$7 \$9	
Druge to treat	Tier 2	\$16		\$16	
Drugs to treat illness or				V .0	
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	0 (" (, , , , , , , , , , , , , , , , ,	·		·	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$75	
services	Physician/surgeon fees	10%		\$20	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150 \$175		\$150 \$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need		-		_	
immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$225 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		5 days	
1100pital otay	Physician/surgeon fee	10%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
behavioral 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	•			\$125 per day up to	
other special health needs	Skilled nursing care	10%		5 days	
neatur 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	99		90	
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				
Basic		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					
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Bei	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-on Platinum Coinsurance	Ĭ	CCSB-onl Platinum Copay Pla	Ĭ
Actuarial Value - A	V Calculator	91.3% <u>91.8</u>	10/0	90.5% <u>91.1</u>	%
Actuariai value - A	Plan design includes a deductible?		<u>170</u>	90.5% 91.1 No	<u>70</u>
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0 / \$0 / \$	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	
-	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$30 \$100	
	Tier 1	\$10		\$5	
Drugs to treat	Tier 2	\$25		\$20	
condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient 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 immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	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	
Hali	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
Help recovering or				\$150 per day up to	
other special health needs	Skilled nursing care	10%		5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
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 Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

Medically necessary orthodontics

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - A\		81.5% <u>81.4</u> '	<u>%</u>	81.6% <u>81.7</u>	<u>7%</u>
	Plan design includes a deductible?	No eo		No \$0	
	Integrated Individual deductible Integrated Family deductible	\$0 \$0		\$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	\$ 8,700 <u>\$9,2</u> 0	<u>00</u>	\$ 8,700 <u>\$9,2</u>	200
	Family Out-of-pocket maximum	\$17,400 <u>\$18,</u> 4	<u>400</u>	\$17,400 <u>\$18</u>	<u>,400</u>
	HSA plan: Self-only coverage deductible	N/A N/A		N/A N/A	
Common Medical	HSA family plan: Individual deductible Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
Event	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$40</u>	присо	\$35 <u>\$40</u>	тфрисс
Health care provider's	Other practitioner office visit	\$35 <u>\$40</u>		\$35 <u>\$40</u>	
office or clinic visit	Specialist visit	\$65 \$70		\$65 \$70	
Cillic Visit	·	, , , , ,			
	Preventive care/ screening/ immunization	No charge		No charge	
Tooto	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$15 \$18		\$15 \$18	
Drugs to treat	Tier 2	\$60		\$60	
illness or	Tion 2				
condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%		\$130	
Outpatient	Physician/surgeon fees	30%		\$60	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$330 \$350		\$330 \$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250	
immediate attention	wedical transportation (including emergency and non-emergency)	\$250		\$250	
	Urgent care	\$35 <u>\$40</u>		\$35 <u>\$40</u>	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		\$350 \$375 per day	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%		up to 5 days	
Mental		30%		No charge	
health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$35 <u>\$40</u>		\$35 <u>\$40</u>	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35 <u>\$40</u>		\$35 <u>\$40</u>	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$40</u>		\$35 <u>\$40</u>	
recovering or other special	Skilled nursing care	30%		\$150 per day up to	
health needs	Durable medical equipment	20%		5 days 20%	
	Hospice service	No charge		No charge	
Ohild	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	ivo charge		ino charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	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	Medically necessary orthodontics	Not Covered		Not Covered	

Not Covered

Not Covered

9.5 EHB

•	nefits and Coverage	CCSB-only		CCSB-only	
-	-	Gold		Gold	
MELLINEL COST SUBLE	amounts describe the Enrollee's out of pocket costs.	Coinsurance Pla	n	Copay Plan	
Actuarial Value - A\	/ Calculator	70 10/ 00 20/		90 E0/, 91 70/,	
Actuariai value - Av		79.1% <u>80.3%</u>		80.5% <u>81.7%</u>	
	Plan design includes a deductible?		acy	Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care		,		,,,,	
provider's	Other practitioner office visit	\$25		\$35	
office or clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$40	
illness or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	X
Outpatient	Physician/surgeon fees	20%		\$35	
services	·				
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х
immediate attention				·	
attention	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	Х	\$600 per day up to 5 days	Х
Hospital stay	Physician/surgeon fee	20%	x	No charge	
Mental					
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
behavioral health, or					
substance 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 recovering or	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
01.11.1	' 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 Daniel	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Course		Not Coursed	
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dantal					
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		N 10		N 10	
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB

Cummon		Donofito	and	Coverage
Summarv	v ot	Benefits	and	Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	Plan
Actuarial Value - A\	V Calculator	71.6% <u>71.8%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	/ (CO
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 \$5,200 / \$50	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$ 10,800 <u>\$10,400</u> / \$10 \$ 8,700 <u>\$9,800</u>	ΙΟ / ΦΟ
	Family Out-of-pocket maximum	\$17,400 <u>\$19,600</u>	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care provider's 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	\$18	
	Tier 2	# 00	Pharmacy
Drugs to treat illness or	Tier 2	\$60	deductible
condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy
		after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	30%	
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$50	
	Casility for /o a boonital room) for impatient stay / including labor and		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and 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	***	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
abuse needs			
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other special	Skilled nursing care	30%	X
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child D	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	5510104	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	1101 0010100	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	1 Tookisuusiikuus		
	Oral Surgery		

•	, 202 4 <u>February 20, 2025</u>				
-	efits and Coverage	CCSB-only Silver		CCSB-only Silver	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan	1	Copay Plan	
A	101.11	00 50/ 74 00/		00.40/.70.00/	
Actuarial Value - A\		69.5% <u>71.2%</u>		69.1% <u>70.8%</u>	
	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 / \$	
	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
Event	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care	Other practitioner office visit	\$55		\$55	
provider's office or	Office practitioner office visit	φοσ		φοσ	
clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
Tests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	X	\$300	X
	Tier 1	\$20		\$19	
_	Tier 2	¢75	Pharmacy	¢o.c	Pharmacy
Drugs to treat illness or		\$75	deductible	\$85	deductible
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%	X	35%	X
Outpatient services	Physician/surgeon fees	35%		35%	
services	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	x	35%	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	35%	x	35%	X
immediate attention	Urgent care	\$55	^	\$55	^
	organic care	Ψ55		ψ55	
110-111	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	×	35%	X
Hospital stay	Physician/surgeon fee	35%	Х	35%	
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	
Holm	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
Help recovering or			V		V
other special health needs	Skilled nursing care	35%	X	35%	Х
	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	1101 0070100		Tion Covered	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	r
tuarial Value - A\	/ Calculator	71.2% <u>70</u>	. <u>6%</u>
	Plan design includes a deductible?	Yes, integ	
	Integrated Individual deductible	\$ 2,850 \$3,200	integrated
	Integrated Family deductible	\$5,700 <u>\$6,400</u>	integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out–of–pocket maximum	\$ 7,500 <u>\$8</u>	
	Family Out-of-pocket maximum	\$15,000 <u>\$1</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$2,850 See endr	
Common Medical Event	Service Type	Member Cost Share	Deductible Appl
	Primary care visit to treat an injury, illness, or condition	25%	х
Health care provider's	Other practitioner office visit	25%	x
office or	Consideration in the	050/	
clinic visit	Specialist visit	25%	X
	Preventive care/ screening/ immunization	No charge	
Tank	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	Х
	Tier 1	25% up to \$250 per script	X
	Tier 2	25% up to \$250 per	×
Drugs to treat illness or	nei 2	script 25% up to \$250 per	^
condition	Tier 3	script	X
	Tier 4	25% up to \$250 per script	×
	Surgery facility fee (e.g., ASC)	25%	X
Outpatient	Physician/surgeon fees	25%	x
services			
	Outpatient visit	25%	X
	Emergency room facility fee (waived if admitted)	25%	X
	Emergency room physician fee (waived if admitted)	0%	X
Need immediate	Medical transportation (including emergency and non-emergency)	25%	X
attention	Urgent care	25%	х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	Х
1103pital Stay	Physician/surgeon fee	25%	×
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	25%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	х
Help	Outpatient Rehabilitation and Habilitation services	25%	x
recovering or	Skilled nursing care	25%	X
other special health needs	Durable medical equipment		
		25%	X
	Hospice service	0%	X
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 and	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		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

Summar	y of	Benefits	and	Coverage
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ember Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	-
ctuarial Value - A\	√ Calculator	94.7% <u>94</u>	. <u>8%</u>	88.0% <u>87.9%</u>	
	Plan design includes a deductible?	Yes, Medical/Ph	armacy No	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$1,400 / \$350 <u>\$50</u> /	\$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$2,800 / \$700 <u>\$100</u>	/ \$0
	Individual Out-of-pocket maximum	\$,1300 <u>\$1</u>		\$3,050 <u>\$3,350</u>	
	Family Out-of-pocket maximum		<u>2.800</u>	\$ 6,100 <u>\$6,700</u>	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
LVCIII	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or				·	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8 \$10		\$20 <u>\$30</u>	
Tests	X-rays and Diagnostic Imaging	\$8 \$10		\$40 <u>\$50</u>	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
illness or	Tion 2	¢15		¢4E	Pharmacy
condition	Tier 3	\$15		\$45	deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharmacy deductible
0.1	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient services	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150 \$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention					
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	10%	X	20%	Х
	Physician/surgeon fee	10%		20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral	visits	ΨΟ		Ψισ	
health, or substance 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	
Uoln	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or			V	·	V
other special health needs	Skilled nursing care	10%	X	20%	Х
needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	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				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
JUI 11003	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPl	_
	40.1.1.		
tuarial Value - A\	/ Calculator Plan design includes a deductible?	73.9% 73.8% Yes, Medical/Pharm	1204
	Integrated Individual deductible	res, iviedical/Priam	iacy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 5,400 \$ <u>5,200</u> / \$ 350 \$ <u>50</u> / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 <u>\$10,400</u> / \$700 <u>\$</u>	<u>\$100</u> / \$0
	Individual Out-of-pocket maximum	\$7,350 <u>\$8,100</u>	
	Family Out-of-pocket maximum	\$14,700 <u>\$16,200</u>	<u>)</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductik Applies
Event	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$50</u>	
Health care provider's	Other practitioner office visit	\$35	
office or		_	
clinic visit	Specialist visit	\$ 85 <u>\$90</u>	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$20 <u>\$19</u>	
Druge to treet	Tier 2	\$55	Pharma
Drugs to treat illness or			deductit Pharma
condition	Tier 3	\$85	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%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350 \$400	
	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35 <u>\$50</u>	
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%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35 <u>\$50</u>	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35 <u>\$50</u>	
abuse needs		No shaws	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35 <u>\$50</u>	
other special	Skilled nursing care	30%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	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	1101 0010100	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		

9.5 EHB

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan		Bronze HDHP Plan	
ctuarial Value - AV Calculator		63.6% <u>63.7%</u>		64.9% <u>64.8%</u>	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, integrated	
Integrated Individual deductible		N/A		\$ 6,650 \$7,200 integrated	
	Integrated Family deductible	N/A		\$13,300 <u>\$14,400</u> integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	60	N/A	J
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /		N/A	
	Individual Out-of-pocket maximum	\$8,850 \$9,800		\$6,650 \$7,20	חחי
	·	\$1,7700 \$19,600			
	Family Out-of-pocket maximum	., .,	U	\$13,300 \$14,400	
	HSA plan: Self-only coverage deductible	N/A		\$6,650	
Common	HSA family plan: Individual deductible	N/A		\$6,650	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$60		0%	X
provider's	Other practitioner office visit	\$60		0%	X
office or	Consistint visit	MOF	After 1st three non-	00/	
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40 \$50		0%	X
Tests	X-rays and Diagnostic Imaging	40%	x	0%	x
	Imaging (CT/PET scans, MRIs)	40%	×	0%	×
			^		
	Tier 1	\$19 \$20		0%	X
Deve to t	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X
Drugs to treat illness or	•	pharmacy deductible	Deductible	J 70	_ ^
condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
		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%	X	0%	Х
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need	Medical transportation (including emergency and non-emergency)	40%	x	0%	X
immediate					
attention	Harant ann	000		00/	
	Urgent care	\$60		0%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	Х
Hospital stay	Physician/surgeon fee	40%	×	0%	x
Mental			,	0,0	, ,
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	x
behavioral health, or					
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%	X	0%	х
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	X
recovering or	·				
other special health needs	Skilled nursing care	40%	X	0%	X
nearth needs	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	х
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	110 Sharge		140 Sharge	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Coursed		Not Correct	
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
Child Day	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
	Endodontics				
Child Dental		Not Covered		Not Covers	
	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services					1
	Prosthodontics				
	Prosthodontics Oral Surgery				

9.5 EHB

Summary of	f Benefits	and Coverage
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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	\$9,200 \$10,150 integrated			
	Integrated Family deductible	\$18,400 <u>\$2</u>	0,300 integrated		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	N/A \$ 9,200 \$10,150			
	Family Out-of-pocket maximum		00 \$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		
Health care	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits		
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 treat	Tier 2	0%	х		
illness or	Tier 3	0%			
condition	Her 3	0%	X		
	Tier 4	0%	Х		
	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%	Х		
	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%	Х		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	X		
Mental	Mental/behavioral health and substance use disorder outpatient office	0.0	After 1st three non-		
health, behavioral	visits	0%	preventive visits		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	00/	,		
abuse needs	items and services	0%	X		
Pregnancy	Prenatal care and preconception visits	No charge	V		
	Home health care (cost share per visit)	0%	X		
Help recovering or	Outpatient Rehabilitation and Habilitation services	0%	X		
other special health needs	Skilled nursing care	0%	X		
	Durable medical equipment	0%	X		
	Hospice service	0%	Х		
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	X		
	Oral Exam	U /U	^		
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	Not Covered			
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	N-4 C			
Basic Services	Periodontal Maintenance Services	Not Covered			
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered			
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered			

Medically necessary orthodontics

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil		CA Enh CSR Silver 8	
	·	100%-1509	% FPL	150%-200% FPL	
uarial Value - A\	V Calculator	95.1% <u>95</u>	5.4 <u>%</u>	88.9% <u>89.6%</u>	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$0 / \$0	/ ¢ ∩	N/A \$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$1,15		\$3,000	
	Family Out-of-pocket maximum			\$6,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Dedu App
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
ealth care rovider'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	
lmine to the	Tier 2	\$10		\$25	
rugs to treat Iness or		ψ10		·	
ondition	Tier 3	\$15		\$45	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
	Surgery facility fee (e.g., ASC)	10%		20%	
outpatient 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	
eed nmediate ttention	Medical transportation (including emergency and non-emergency)	\$30		\$75	
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100/		200/	
lospital stay	delivery, mental health, and substance use)	10%		20%	
	Physician/surgeon fee	10%		20%	
lental ealth, ehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ealth, or ubstance buse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
elp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
ecovering or ther 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	pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge	
child Dental	Preventive - Cleaning				
iagnostic nd	Preventive - X-ray	Not Covered		Not Covered	
reventive	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				
hild					

Not Covered

Not Covered

2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB Date: April 18, 2024 February 20, 2025

	, 202 4 <u>February 20, 2025</u> nefits and Coverage			
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Plan Above 200% FPL		
ctuarial Value - A\		79.2% <u>80.4%</u>		
	Plan design includes a deductible?	No N/A		
	Integrated Individual deductible Integrated Family deductible	N/A 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			
	Family Out-of-pocket maximum	\$12,200		
	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	\$35		
Health care provider's	Other practitioner office visit	\$35		
office or clinic visit	Specialist visit	\$85		
Cillio Visit	Preventive care/ screening/ immunization			
	•	No charge \$50		
Tests	Laboratory Tests			
10313	X-rays and Diagnostic Imaging	\$95		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$15		
Drugs to treat	Tier 2	\$55		
illness or condition	Tier 3	\$85		
condition	Hel 3	φοσ		
	Tier 4	20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	30%		
Outpatient services	Physician/surgeon fees	30%		
	Outpatient visit	30%		
	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
Need	Medical transportation (including emergency and non-emergency)	\$250		
immediate attention				
	Urgent care	\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%		
Mental	, ,	30 /0		
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		
behavioral health, or	Montal/hohaviaral hoalth and authorary and district the state of the s			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$40		
Holp	Outpatient Rehabilitation and Habilitation services	\$35		
Help recovering or	Skilled nursing care	30%		
other special health needs	· ·			
	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning			
	Preventive - X-ray	Not Covered		
and Preventive	Sealants per Tooth	2310100		
. 70 Females	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Basic Services	Periodontal Maintenance Services	NOT Covered		
	Crowns and Casts			
Child Dantal	Endodontics			
Child Dental Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			
Child	Medically necessary orthodontics	Not Covered		
Orthodontics	,, 5.1.1545111155	1401 0040100		

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;
	2) Drugs that are recommended by P&T committee based
3	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.